Top Tier Provider Network Research Results

Washington State Department of Labor & Industries
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Introduction

In 2011, Washington state lawmakers approved workers' compensation reform (Substitute Senate Bill 5801). Part of this reform mandated that L&I establish a new Provider Network, including a "top tier" designation for medical providers who use occupational health best practices. To qualify providers for this designation, L&I created draft criteria in conjunction with the Provider Network Advisory Group. The purpose of this research was to understand how the broader provider community felt about the draft criteria.

Specifically, the goals of this research were to understand how providers perceive the top tier criteria and if they would consider adopting the best practices and applying to participate in the top tier.

We wanted to learn:

- Value: What are providers' impressions of the top tier criteria? Do they think the criteria would identify providers appropriately?
- Adoption: Would they consider adopting these practices in order to qualify for the top tier? Are they already implementing them? What non-financial and financial incentives would motivate them to join?
- Existing practice: How do the proposed practices required by the top tier fit within their current practices?

This report details the results of the research. First, we detail the methodology used in conducting the research, including an overview of the participants. Second, we report on the findings and recommendations related to the top tier criteria. Third, we report additional findings about the relationship between providers and L&I that goes beyond the top tier.

The research outlined in this report was conducted by Anthro-Tech with close collaboration and input from the L&I's Health Services Analysis program.

Methodology

To answer the research questions, we conducted an online survey and focus groups. Using a mixed methods approach, we combined quantitative and qualitative research in order to leverage the complementary strengths of both. The online survey yielded quantitative data, which provided larger sample sizes and more representation across the L&I providers. The qualitative approach of focus groups provided an opportunity to explore the research questions in more depth and gain a deeper understanding of opinions and issues related to the creation of a top tier. In this section, we provide more detail about each research method.

Survey

The online survey was conducted between June 8 – 28. A call to participate in the survey was distributed via the L&I Medical Provider News email list (known internally the L&I provider listserv). The call was sent to the listserv on June 8 and again on June 18. The call to participate in the survey was also distributed through the Centers for Occupational Health and Education (COHEs). The questions were developed in conjunction with L&I's Health Services Analysis to gather a deeper understanding of providers current practices and their opinions of the criteria for top tier. To see the questions asked in the online survey, see Appendix A: Survey.

Since the research was focused specifically on attending providers who treat at least 12 injured workers per year, we screened out any responses from those who did not fit this criteria, including administrative staff, vocational providers and non-attending providers like massage therapists. As a result, we had a total of 184 providers complete the survey. This sample was from the total population of L&I attending providers, which is estimated to be 17,000. This sample constitutes a reasonable cross section of respondents to allow us to draw conclusions that would apply to the larger population. For more details about the sample, confidence intervals and margins of error, see Appendix C on page 58. In addition, since we had a diverse set of providers complete the survey, there were differences of how they answered the questions based on their role. The report shows the aggregate data for survey results, but we have also provided role-based results in the appendices.

Focus Groups

The focus groups were conducted June 26 – 28 in Spokane and Seattle. Each 90-minute session was facilitated by an experienced moderator and captured on video. A total of 25 providers participated (13 in Spokane and 12 in Seattle) with representation from a variety of attending providers and specialties. For more details on the specific questions asked during the session, please see Appendix B: Focus group discussion guide.

For the focus groups, participants were recruited in several ways; at the end of the

online survey, participants were asked to list contact information if they were interested in taking part in other research. L&I staff also contacted other interested providers through outreach efforts through the COHEs and with a variety of medical associations and professional organizations such as the County Medical Associations, Washington State Medical Association, the Washington State Physicians Assistants Association, The Washington State ARNP Association, and others.

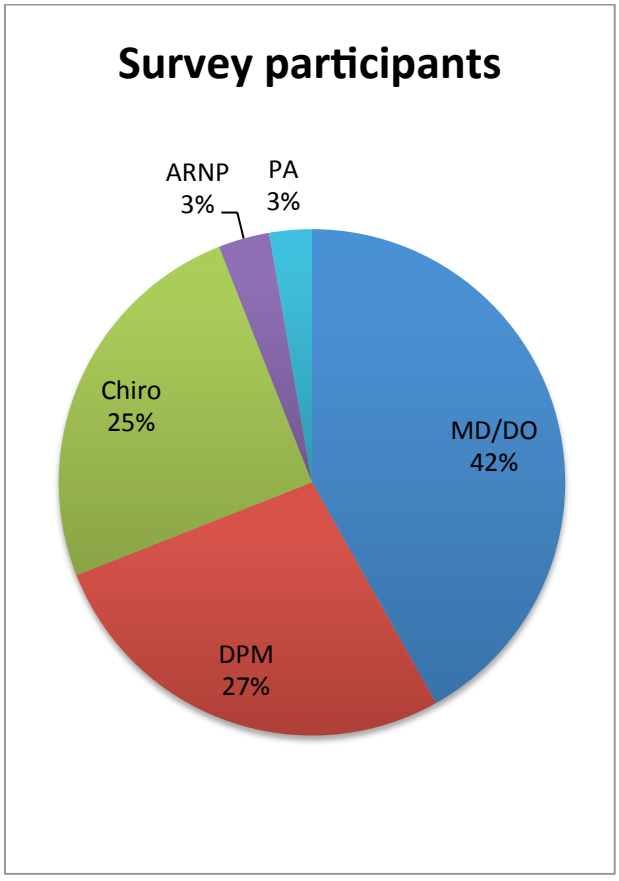
To ensure participants in the focus groups met the criteria for the research sample, they were screened by L&I staff and asked questions related to their practice, such as the number of injured workers they treat and size of practice. The 25 participants who participated represented a cross-section of L&I providers to ensure we could solicit opinions from a number of specialties or roles. Having groups that were a mix of specialties and roles was beneficial to the research because it provided a deeper conversation about some of the issues we were interested in, such as coordinated care. Despite recruitment efforts, we had only one PA participate and no involvement from ARNPs. Therefore, this report may not completely address their concerns.

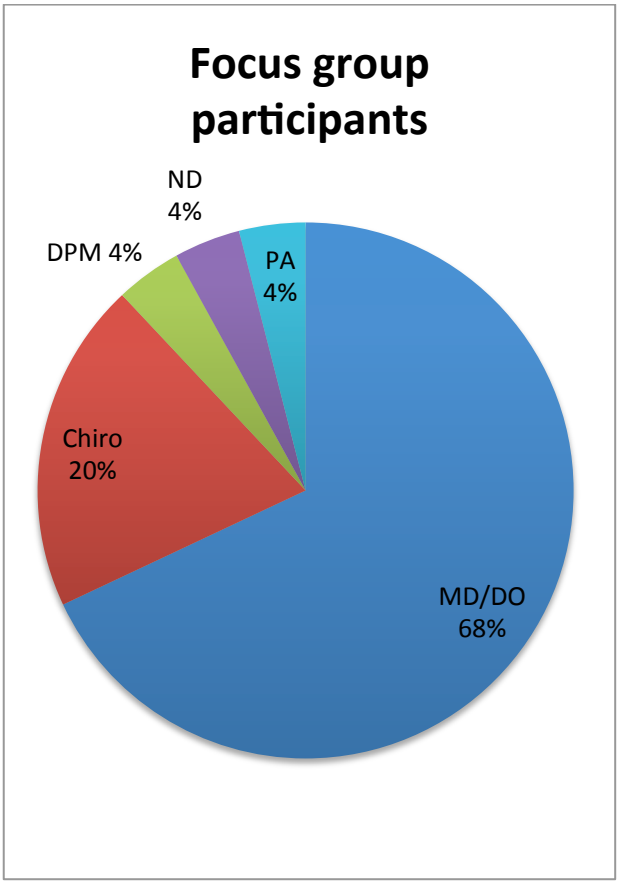
The provider listserv was used to recruit participants for both research activities, which means the resulting sample was not selected at random. Subscribers to the provider listserv are already working with L&I and interested in learning more about new programs and offerings. Therefore, although the sample was self-selected, we are confident that the feedback from the providers who took part in the research reflects opinions for people who are interested in learning more about the top tier program. The next section shows more information about who took part in the research.

Participants at a glance

In the following section, we provide more background on who participated in both the survey and focus groups

By role





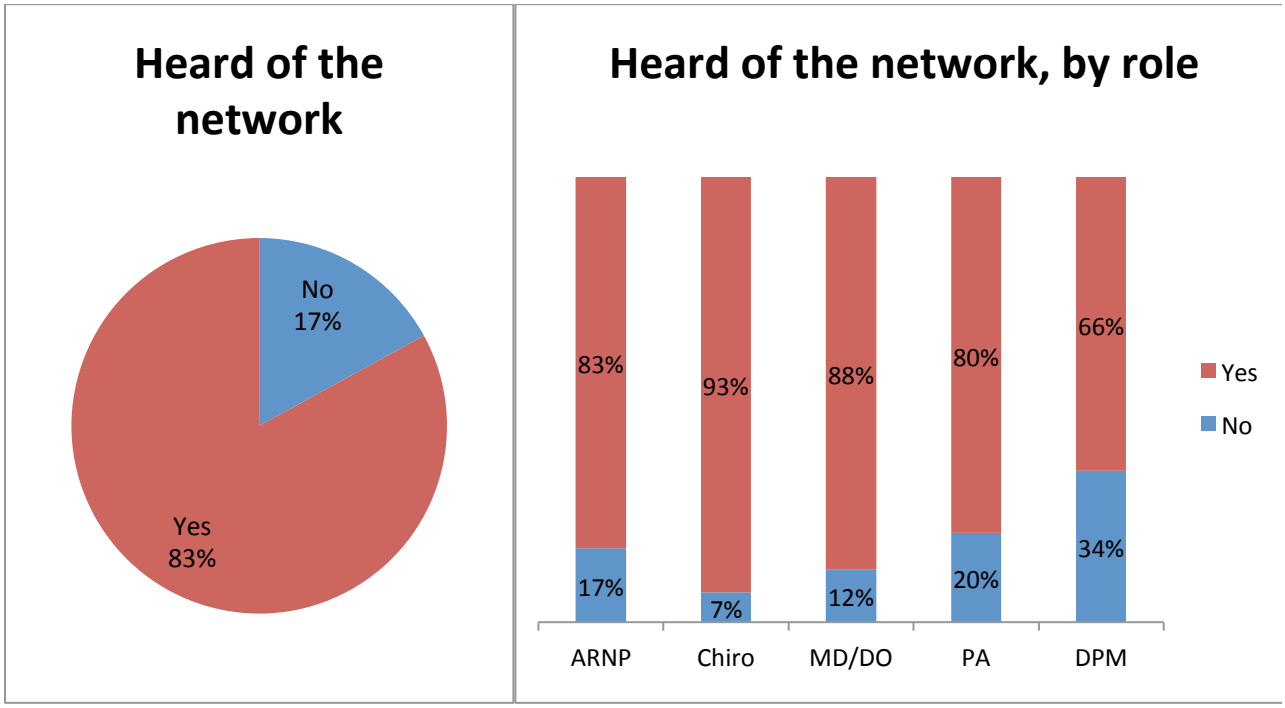
Survey participants (n=184)

Focus group participants (n=25)

Figure 1. Participants, by method and role

Awareness of the provider network

According to the survey, most participants were aware of the L&I provider network. Looking closer by role, DPMs (podiatrists) were the least aware of the network, while chiropractors were the most aware.

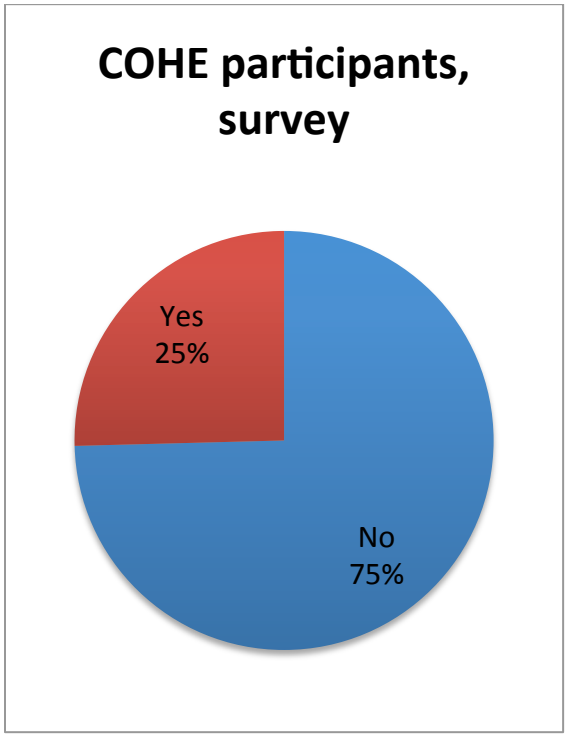


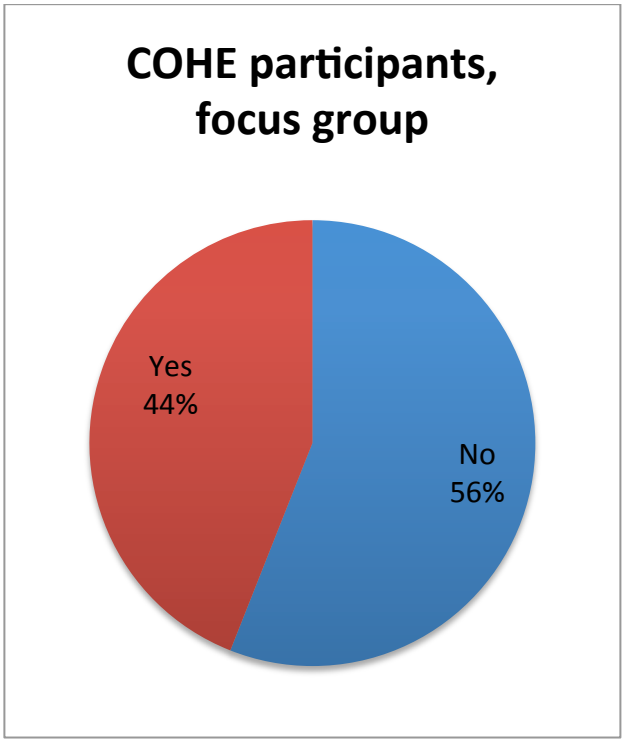
n=182 *ARNP (n=6), Chiro (n=46), MD/DO (n=76), PA (n=5), DPM (n=50)*

Figure 2. Survey participants' awareness of the provider network

Participants enrolled in a COHE

In the survey, 25% of participants were members of a COHE. In the focus groups, 44% were members of a COHE. The Eastern Washington focus groups were made up of almost all COHEs while the Western Washington focus groups had no COHE members.





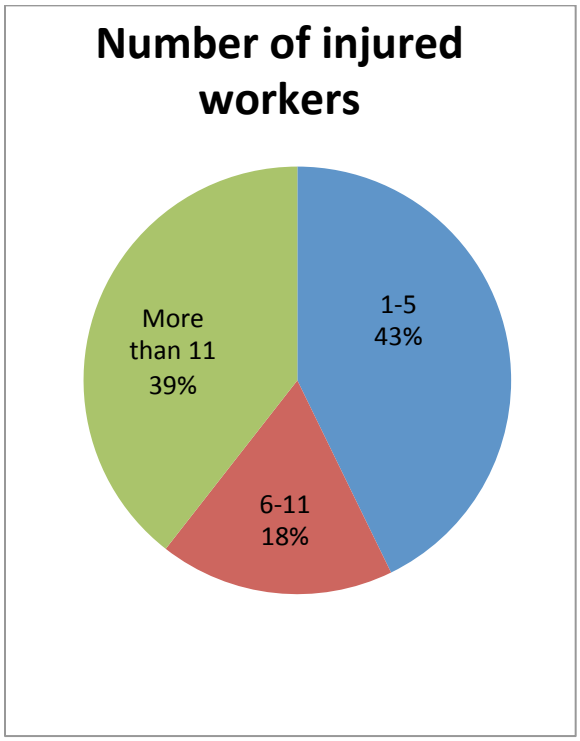
Survey participants (n=181)

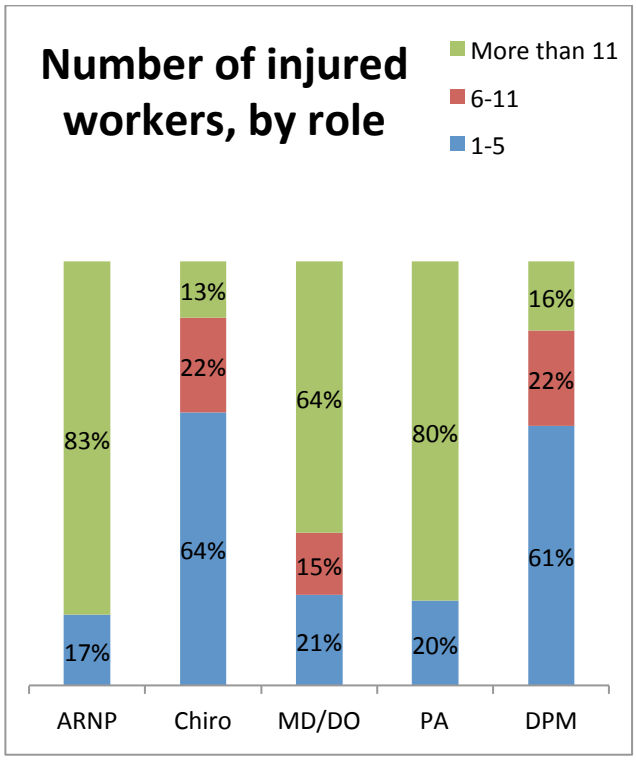
Focus group participants (n=25)

Figure 3. Participants enrolled in a COHE

Number of injured workers they treat

Out of all respondents who completed the survey, most treat 1-5 injured workers per month.





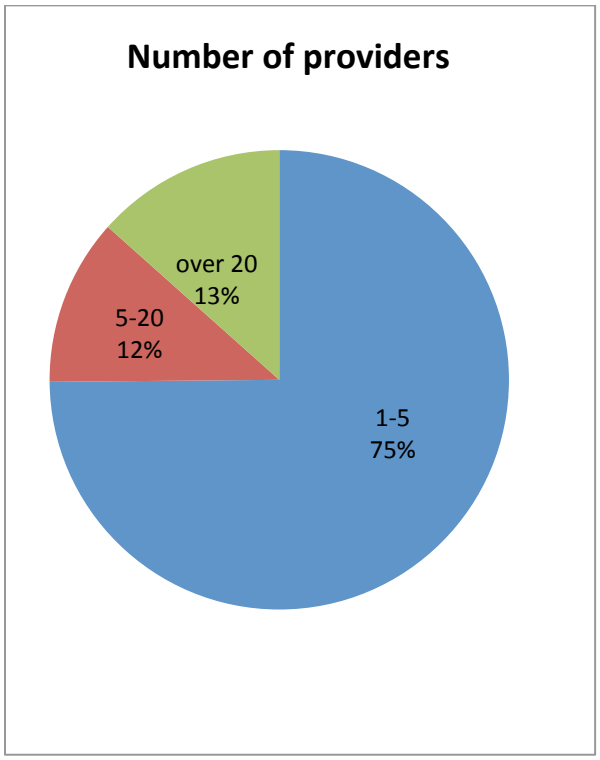
n=180

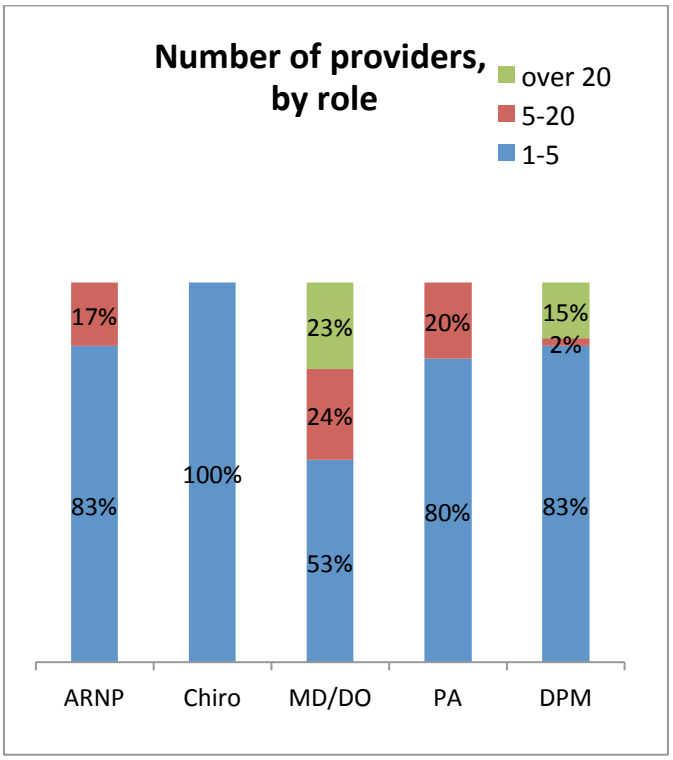
ARNP (n=6), Chiro (n=45), MD/DO (n=76), PA (n=5), DPM (n=50)

Figure 4. Survey participants and number of injured workers treated per month (according to the survey)

Number of providers in the practice

Out of all respondents who completed the survey, 75% work at a practice with less than 5 providers.





n=179

ARNP (n=6), Chiro (n=45), MD/DO (n=75), PA (n=5), DPM (n=48)

Figure 5. Survey participants' number of providers in participant practice (according to the survey)

Additional details about focus group participants

The focus group participants were comprised of a diverse set of attending providers.

- There were a total of 25 participants in the 4 focus groups:
  - 13 in Spokane
  - 12 in Seattle
- There was a mix of women and men:
  - 6 women
  - 19 men
- There was a variety of practice types:
  - Occupational Medicine: 6 MD
  - Urgent Care: 3 MD, 1 PA
  - Orthopedic Surgery: 3 MD
  - Chiropractor: 5 MD
  - Psychiatry: 1 MD
  - Physiatry: 2 MD
  - Primary Care: 2 MD
  - Podiatrist: 1 DPM
  - Naturopath: 1 ND
- Size of practice varied from single provider to large organization:
  - 1-5 in practice: 11 or 12 (some did not specify)
  - 6-20 in practice: 3
  - More than 20: 8
  - Unreported: 2
- Monthly number of injured workers reported:
  - 1 – 5 injured workers: 4 practices
  - 6 – 11 injured workers: 2 practices
  - More than 11 injured workers: 12 practices
  - Unreported: 7 practices

Top Tier Criteria:
Findings and Recommendations

In this section we present the findings and recommendations related to the top tier criteria. The findings are organized in the following sections:

- Core competencies
- Best practices
- Qualifying criteria
- Potential incentives
- Interest in applying

For each set of findings we present the main themes derived from data collected in the focus groups and in the survey. Quotes from participants are used to illustrate each of the findings. Quotes were transcribed based on the notes from the study but may have been slightly modified to improve readability.

Core competencies

To qualify for the top tier, providers must demonstrate knowledge in each of the following four core competencies:

- **Care coordination:** having a resource to make sure the treatment plan (both clinical and return to work) is complete and ensuring follow through by all members of the care team. The care team includes consulting providers, ancillary providers, claim managers, vocational staff, employers, etc.
- **Collaboration & Communication:** making sure that all members of the care team have the information they need to provide the best possible care for the patient. This includes being responsive to requests for information from team members who are not clinical providers, such as the employer, vocational counselor, or claim manager.
- **Workers' Compensation:** being familiar with the rules and processes in the Washington State workers' compensation system.
- **Opioid Management:** understanding appropriate use of opioids and alternatives for pain management.

In this section we present the findings related to the four competencies as a whole. We then explore each competency in more detail, report on variation based on role or specialty, and provide recommendations.

Finding: The four core competencies, as a set, seem reasonable and would lead to better outcomes.

This finding is based on results from the survey and the focus groups.

According to survey results, providers:

- Indicate that they have existing knowledge in each of these core competencies, see Figure 6.
- Agree that knowledge in these four areas can lead to better outcomes for patients, see Figure 7.

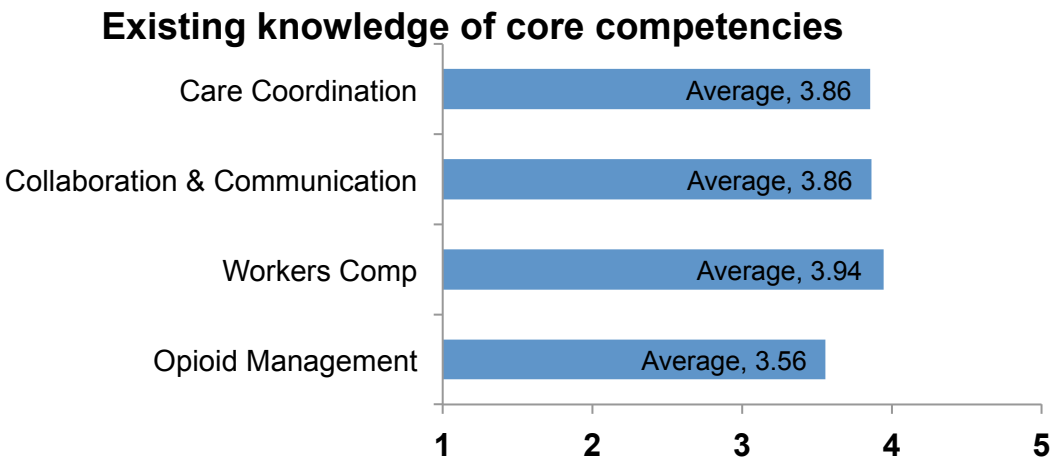


Figure 6. Survey participants rated their existing knowledge of the core competencies on a scale or 1 (low) to 5 (high). (n=156)

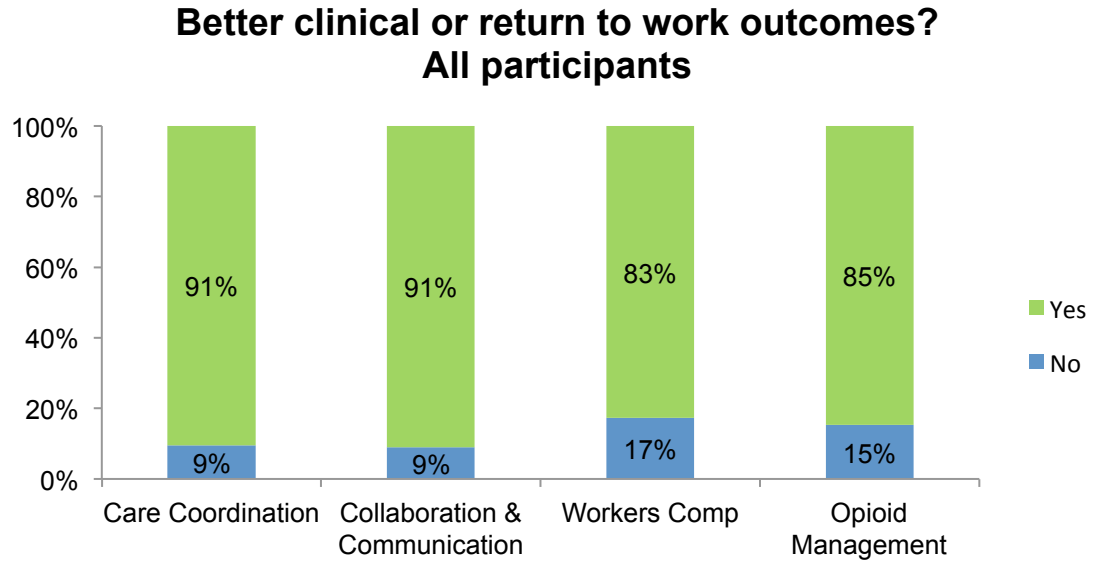


Figure 7. Does provider knowledge of core competencies improve outcomes for injured workers? (n=150)

Finding: Providers have mixed opinions on whether or not L&I could measure these core competencies.

Providers were asked if L&I could measure their knowledge of the core competencies through testing and reviewing a sample of claims. For both questions, over 60% of providers in the survey agreed that L&I could measure knowledge through testing and reviewing a sample of claims. However, providers had a variety of concerns on the execution of the testing and the claims evaluation by L&I.

We probed further on these issues in the focus groups and identified several reasons why providers are concerned about the measurement of knowledge and claims evaluation.

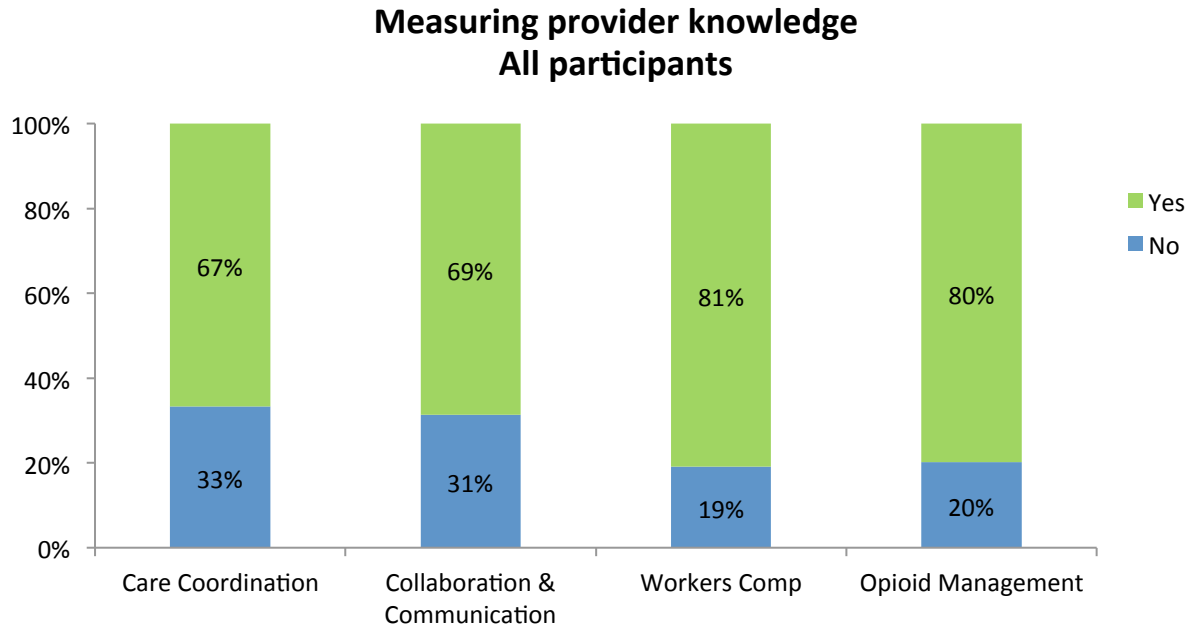


Figure 8. Could L&I measure a provider's knowledge of the core competencies? (n=154)

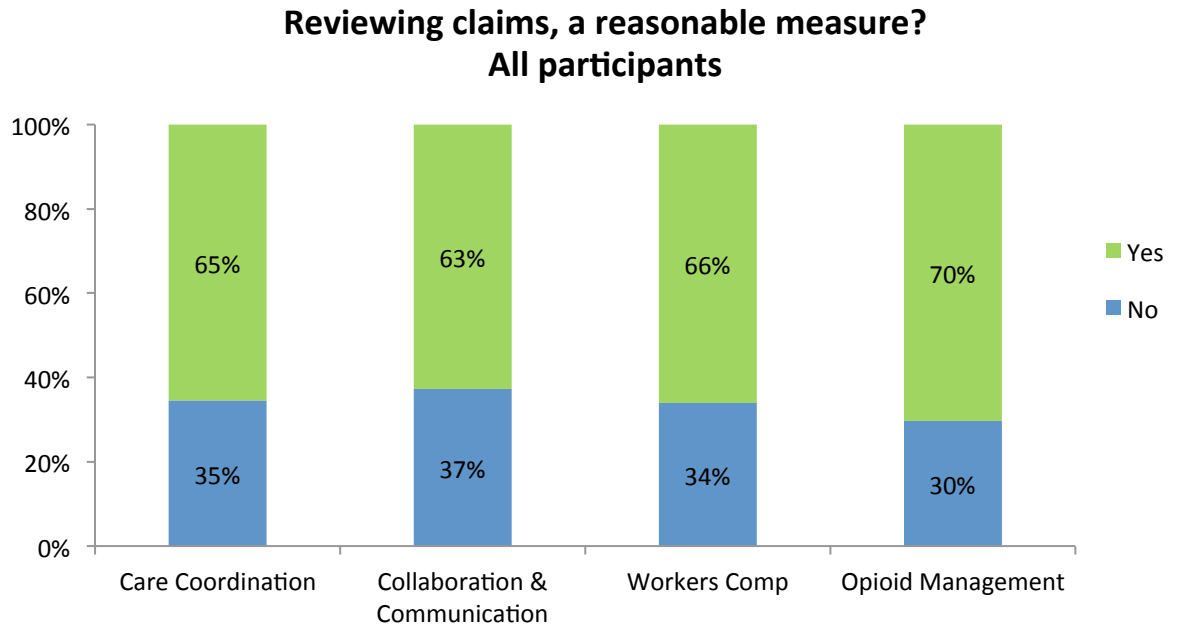


Figure 9. Would reviewing a sample of claims give L&I a reasonable measure of performance? (n=155)

Evaluating existing knowledge

In terms of evaluating existing knowledge, focus group participants saw the value in testing and training in the four competencies. However, they believed that testing and measuring knowledge went hand in hand with training opportunities. Providers concluded that it was reasonable for L&I to evaluate existing knowledge. They wanted the evaluation to be part of a training and testing model.

In each of the focus groups, providers stressed an interest in and need for training opportunities from L&I, specifically online training. In all four focus groups, providers had similar and specific requests for training opportunities.

- **Provide training online:** Continue to provide and expand training modules online, allowing providers to train at their own convenience.
    - *"Online is ubiquitous. We understand how to do it and we can we build it into our schedule, into our cases. It's accessible and standardized which is important."*
- **Make trainings free**: If the courses are free, providers are more willing to take advantage of them.
    - *"Right now to get training, it costs $400 and you have to take a day off work. It's ridiculous."*
- **Award continuing medical education (CME) credits**: Allowing providers to earn credits motivates them to attend the trainings.
    - *"[The training should provide] CMEs for everyone. It's a win-win. We get credits and then at the same time L&I makes sure that everyone is on the same page. Ongoing training is*

helpful, because you forget things. There are new rules and a wealth of information to keep up with."

- *"Online CMEs are terrific. You can do it in 30 minutes and it's free. That's what our academy does. It's online; there is a pre-test, 20 slides and then 5 questions. Don't pummel us with regulations."*

- **Make the training rigorous:** One provider claimed that the current online training, although helpful, was not rigorous because it contained redundant test questions. This was due to the fact that he was taking the current CME online course each year.

Measuring past performance

Providers in the focus groups voiced the following concerns about how L&I would measure a series of claims to assess a provider's past performance.

- **Time**: How far back would they go? Some providers felt that a 3-6 month timeframe would be reasonable.

- **Number of claims:** How many will L&I evaluate? It doesn't seem feasible to evaluate all our claims. Can I help select the ones L&I evaluates?

- **Complexity**: How would the claims be evaluated? What measures could be put in place to acknowledge the uniqueness of each complex claim? Would the claim evaluation of providers who've taken on complex cases put their top tier status at risk?

- **Ability to discuss the claims:** Because each complex claim is unique, some providers wanted the opportunity to discuss complex claims with L&I during the claim evaluation.

  - *"The claim evaluation should be used as an educational opportunity, not punitively, to see if the person is qualified."*

- **Advanced notice:** Participants wanted advance notice from L&I when this evaluation would take place.

Finding: Care coordination is important but challenging. Absorbing the costs of dedicated resource is not feasible for smaller practices.

In this section, we detail more specific findings about the care coordination core competency.

- Providers saw that care coordination was required, necessary and important.
- Providers' main concern with the care coordination competency was related to the contact with the employer. See the section on the employer phone call in Best Practices for more details on page 25.
- Providers say that care coordination is not always easy, but works well when an occupational medicine doctor or a representative from the employer (like a nurse case manager) is involved.
    - *"If you have great care coordination, then from L&I's perspective, the treatment of our claimants will be better."*
    - *"When a nurse comes in to coordinate care, it gets the injured worker back to work sooner."*
    - *"Care coordination is difficult. I love it when I get a call from an occupational medicine doctor and he gives me the flavor of the case." (Surgeon)*
- The concern with this core competency is the requirement of having a dedicated resource to provide this service. Some providers thought this would require an additional staff person in their office and had concerns about how they would absorb this cost and who would take on these responsibilities.
    - *"It sounds like you have to hire an outside resource to do this."*
    - *"For providers to be able to come up with [care coordination and collaboration & communication] we have to develop new internal processes. Otherwise we have to find an FTE to do this work."*
- Smaller offices, in particular, were concerned about being able to fund a dedicated resource to perform this task.
    - *"How would this affect small practices? I do my own front deskwork. Practices that are single or 2-3 doctors aren't going to have the financial resources to hire someone who is specifically focused on that. Maybe there needs to be ways to adjust this competency for smaller practices."*
- Some specialties did not see how their practice fit into the care coordination model. For example, surgeons saw themselves as temporary attending providers and not involved with employers and vocational counselors. Additionally, specialties that focused on complex claims or longer-term claims, such as psychiatrists or physiatrists, did not feel they would be involved with the full spectrum of care coordination.

Finding: Collaboration & communication is also valuable, but not necessarily distinct from care coordination.

In this section, we detail more specific findings about the collaboration & communication core competency.

- Providers agree that collaboration and communication with all members of the care team is important.

- Providers believe that good communication with all parties helps to understand the worker, their injury and therefore how to approach the case.

    - *"With injured workers, it has to go like clockwork."*

    - *"It's important to understand the manner in which to take care of the problem. It's so important to know how the injury occurred, and what the pattern is."*

- Several providers mentioned that they didn't see the distinction between the competencies of collaboration & communication and care coordination. They felt that these two were not separate and some suggested they should be combined.

    - *"The first two [competencies] are redundant and repetitive. Coordination implies communication. It's not difficult to communicate."*

Finding: Participants agreed that knowledge of workers' compensation is crucial. However, many felt that L&I should provide more information and guidance to providers.

- All providers agreed that the main way to learn about workers' compensation and L&I was to take on injured workers as patients. They thought that the way to learn about the process was through practice and trial and error.

    - *"There is a lot of little stuff that you're not going to know until you do it."*

- Providers who did not have specialized training in occupational medicine felt they had overcome a steep learning curve prior to taking workers comp cases. Working with L&I was part of this learning curve.

- Several providers voiced frustration about unclear expectations from L&I. They felt that, if they were going to be evaluated based on their knowledge of workers' compensation, L&I should provide resources, training, and clearer instruction.

- Providers were unaware of all the available L&I training resources. Some used the web site, the Claims & Account center, and provider bulletins. Others did not know these existed.

    - *"I subscribe to the newsletter through email. That's where you get helpful updates on rules. I keep them in my email. I just remember, their not covering xyz and send it to my colleagues in my practice."*

Finding: Opioid management is a valuable core competency. However, some specialties have lower knowledge on this topic.

In this section, we detail more specific findings related to opioid management.

- Providers universally agreed that understanding opioids is key, especially since opioid use could derail the injured workers' recovery efforts. Some providers in the focus groups chose never to prescribe opioids because of this issue.

- Not every specialty has equal knowledge on opioid management. Attending providers in the focus groups who did not prescribe medications, like chiropractors and naturopaths, knew less about opioids and were unsure if they should be included in the testing of this particular core competency. This supports the survey data that shows chiropractors rate their existing knowledge as low (see survey data on page 62).

    - *"The only management we do on opioid use is that we document who we're collaborating with. We document that they are using them and that's what is going on." - chiropractor*

- However, some chiropractors in the focus groups felt that it would be helpful to have more knowledge about opioids, particularly when treating patients who had a history of opioid use. They also thought that the opioid issue should be considered good care coordination and that all people involved with the injured worker should be aware of opioid use. This indicates that chiropractors may be open to being tested in their knowledge of opioid use, but would need readily available training materials.

    - *"If we see some suspect behavior, we let the other doctors know. We tell them if this person seems to be ramping up and keep them alert to what we are hearing." – chiropractor*

- Some providers wondered if the core competency could be broadened from opioids in particular, to a more generalized pain management competency. However, due to the diversity of the L&I provider audience, this might be more difficult to define.

Recommendation: Streamline and simplify the core competencies.

Streamline and simplify competencies:

- When communicating about the four core competencies as a set, describe them as “occupational medicine and workers’ compensation competencies”.

- Combine “care coordination” and “collaboration & communication” into one.

- Consider ways to encourage and support smaller practices that want to qualify for top tier. Options include:
    - not requiring a specific care coordination resource, unless there is a way to provide financial support for that resource.
    - clearly communicating that attending providers can be the care coordination resource in smaller practices.

- Continue to require opioid management and workers’ compensation as part of the core competency criteria and provide ways for all providers to increase their knowledge in these areas.

- Suggestions for testing existing knowledge
    - Test competencies based on a set educational model.
    - Provide online training linked with CMEs and create a testing module to evaluate knowledge from the training.
    - Make online training opportunities diverse, robust, relevant, and rigorous.

- Suggestions for claim evaluation:
    - Clarify parameters of claims evaluation and clearly communicate the time frame (6 months seems reasonable).
    - When claims are evaluated, consider how to provide the outcomes of the evaluation as a learning opportunity. If a provider does not qualify based on this evaluation, consider what resources or information would help providers continue to grow their knowledge.

Best practices

L&I identified three administrative occupational health best practices that would be potential criteria for top tier status.

- Submit the Report of Accident to L&I within 2 business days.
- Complete an Activity Prescription Form (APF) early in the claim.
- Make a phone call to the employer to discuss return to work early in the claim.

In this section we present the findings related to these three best practices.

Finding: Current usage of best practices varies.

According to survey data, providers tended to be more likely to comply with the first two best practices rather than the third, as shown in Figure 10 below:

- Submitting the ROA in two business days – 85% responded either sometimes or always.
- Completing an APF earlier in the claim – 91% reported sometimes or always.
- Calling the employer – 58% reported sometimes or always.

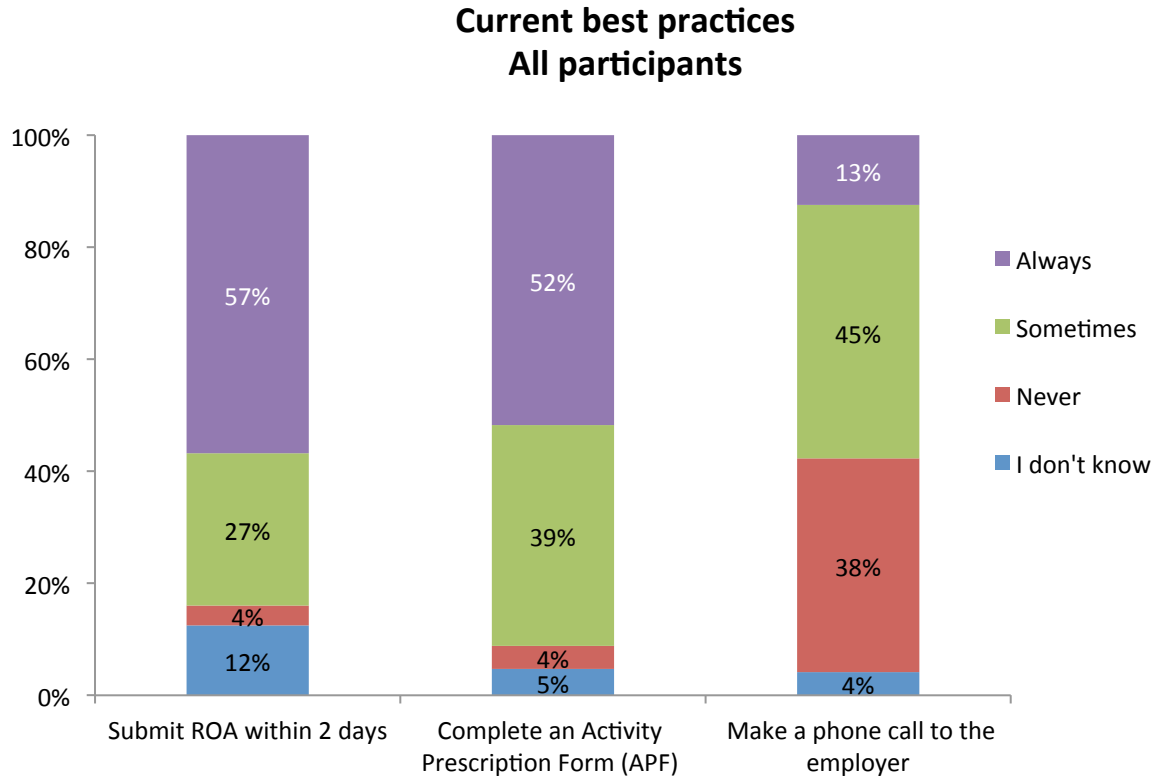


Figure 10. Survey responses to the question, how often do you comply with the three best practices (n=169)

Finding: Providers indicate that the three best practices are reasonable and feasible. However, there is less agreement that the best practices lead to improved outcomes.

The results of this finding were shown in both the survey and the focus groups.

According to the survey, providers agreed that the best practices were reasonable (see Figure 11) and feasible (see Figure 12).

- For the ROA, 82% of providers agreed it was reasonable and 84% agreed it is feasible.
- In the case of the APF, 93% of providers agreed that it was reasonable and feasible.
- As with other questions related to the best practices, there was less agreement on the employer phone call.

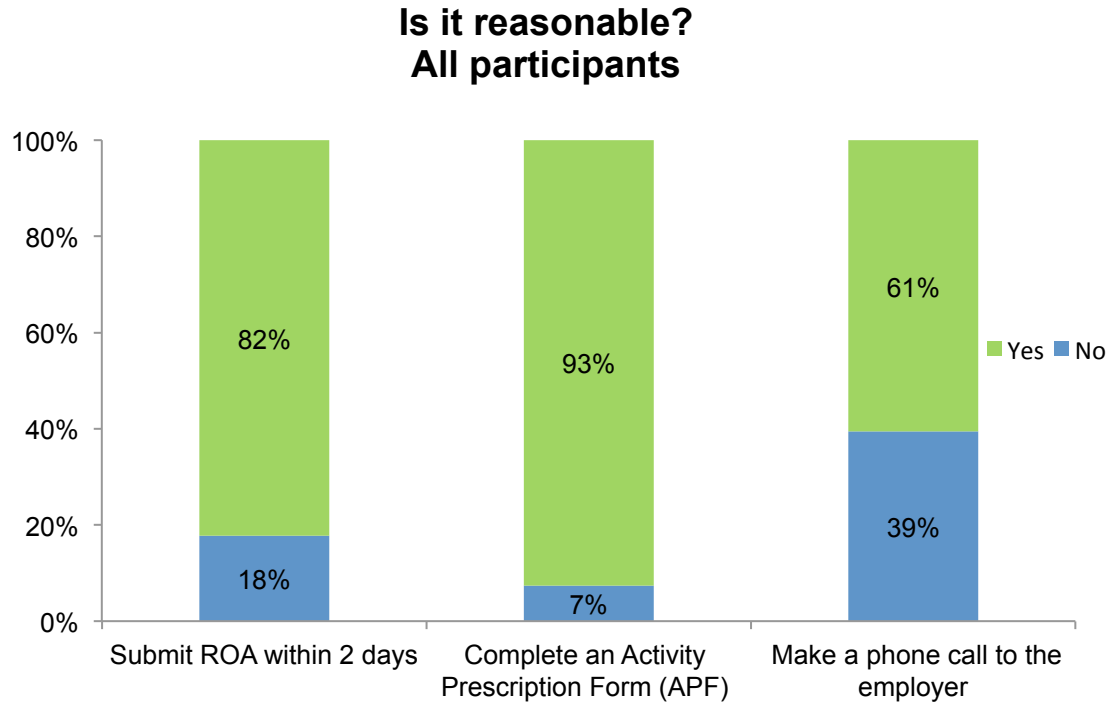


Figure 11. Survey responses to the question: are the best practices reasonable? (n=165)

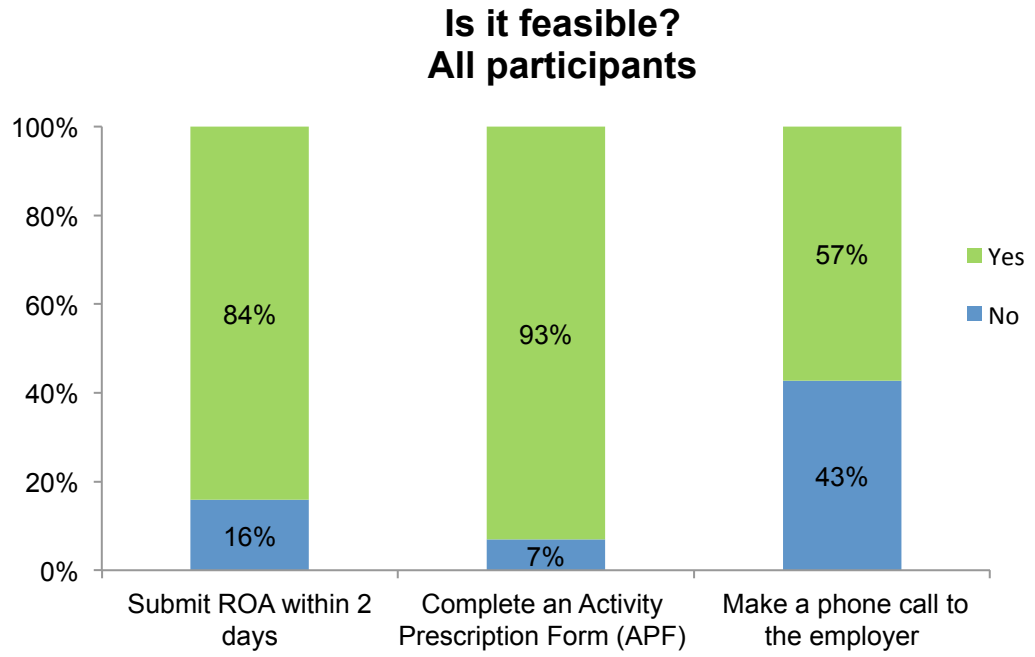


Figure 12. Survey responses to the question: are the best practices feasible in your practice? (n=166)

While most providers agreed that the three best practices led to better outcomes, there was less agreement on this point in contrast to other best practices. (see Figure 13).

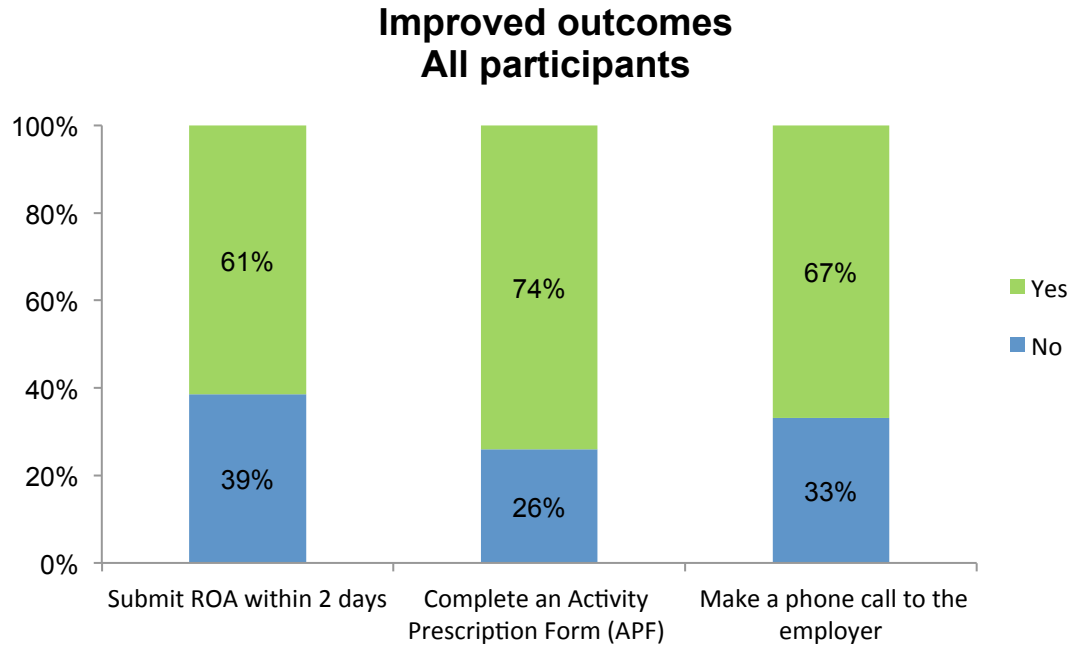


Figure 13. Survey responses to the question: do the best practices lead to improved outcomes? (n=166)

Finding: Submitting the Report of Accident (ROA) in two days is reasonable and, in most cases, the current practice.

- Providers thought that submitting the ROA within two business days was a reasonable request. They assumed that it would help to move the case forward quickly and help to get the claim processed so ongoing treatment could occur.
    - *"Two days is reasonable, it should be an exception if you do not complete it in two days"*
- Occupational Medicine and Urgent Care Providers reported that they regularly fill out the ROAs, usually the same day. If they see a patient at the end of the day, they may wait to send the ROA on the following (2nd) day.
- Some of the other specialties reported they usually are not the provider who initiates the Report of Accident and that the claim is already established. In the cases where they do initiate the ROA, they do so within two days.

Finding: Completing the Activity Prescription Form (APF) early in the claim is reasonable. Many providers think the APF is a valuable tool.

- Overall, the APF is perceived as a good tool and a reasonable best practice for top tier providers. The providers were familiar with the APF and believe that it is a measure that is likely to lead to better patient outcomes because it helps to clearly set expectations for recovery and return.
    - *"Filling out an APF within the first two weeks is reasonable for timeloss."*
    - *"The APF sets the stage for discussion about light duty right away. It's helpful."*
- Several providers think that the APF plays a central role in care coordination and its use could be expanded. Many providers did not know that they could see forms and information from other physicians on the case by looking in the Claims and Account Center on the L&I website.
- Seattle providers said they fill out the APF initially and some do them every visit. Several mentioned that they gave the APF to the worker and encouraged them to pass them on to the employer. One provider disliked having to provide the same information on two forms (one to the employer or self-insurance claims) and thought of it as double work. Other providers mentioned that they use the APF as the default and staple it to other forms.
- Eastern Washington providers complete APFs if they are the initial provider. The surgeons and some other specialists are less likely to do so. They have concerns about sending mixed messages from multiple providers that may confuse the employer or the patient. The group agreed that it was valuable to have different perspectives represented by the APF. The solution identified was to have the providers call one another to clarify.

- There was confusion by some providers about who could bill for completing APF and how often.

Finding: Calling the employer, while beneficial, was seen as the most problematic best practice to implement.

- Many of the providers acknowledged that the employer phone call is beneficial and related to improved outcomes. Some spoke of their experience with the employer call and saw how it was beneficial and others were familiar with the literature. Additionally, some saw that the phone call was an opportunity to educate the employer about workers comp.
    - *"I have patients tell me, 'Don't let them put me on light duty, they'll fire me'. I call the employer and tell them specifics. If you can keep them employed for two weeks, you'll save money, they'll get back to work. It's education for the employer."*
- Support for the employer phone call differed based on role and geography. Occupational medicine providers and Eastern Washington providers were more supportive. The Eastern Washington providers were all members of COHEs which may have also been a supporting factor.
- It helped when providers had a closer, regular working relationship with a specific employer.
- Contacting the employer was perceived as likely to build mutual understanding about the type of modified work available and the worker's restrictions and treatment plan.
- The providers who were resistant to this criterion talked about the administrative burden and challenges of trying to reach the employer. They frequently were unable to reach the employer because:
    - They did not have a phone number
    - They did not have the name of person responsible for the worker
    - Supervisors work different shifts than the doctors
    - The responsible person in a large company may be unavailable
    - The employer may not have an interest in getting the particular worker back
    - *"We normally don't call the employer. We're busy the whole day. We don't have time to stop and track down the manager of Costco. I understand it's a best practice. I can take a call from the employer or call them back. We don't have that time anymore to call them."*
    - *"Who are we supposed to call? You have to place a call and find the person to talk to. Who am I supposed to call at Metro? Who am I supposed to call at Amazon?" – DPM*

- *"When we try and do this, 90% of the time it's a waste of time. It's not the right person, the right phone number, the person isn't available. In these positions, turnover is high or the person responsible doesn't know what to do."*

- *"Isn't that what the APF is for? It is the worker's responsibility to give it to the employer and the employer has to decide. The phone call is a redundancy, I don't have time to call and say this is the same thing."*

- A few of the doctors mentioned that they were hesitant to speak with a supervisor because they were concerned about patient privacy and HIPAA.

  - *"I'm not sure what I can divulge to the employer. I don't think I can speak to them without violating HIPAA."*

- Many said that if they had a number to call, they would leave a message and that they would take the call if the employer called them back. This action was considered sufficient to fulfill their duty.

  - *"You can leave a message and bill but it's a waste of time. I staple my card and give it to the injured worker. I say have your employer call me and then we play phone tag."*

  - *"The goal is to see if there is light duty. But I don't have a ton of time. I leave a message to see if the employer can accommodate them. If they don't call back, you just fill out what they can do on the APF."*

- Both Seattle focus groups were very clear that the employer phone call should be removed from the top tier criteria.

  - *"Remove the call to the employer. The vocational counselor should do that. Having us to call L&I makes sense, but the employer doesn't know what to expect."*

  - *"Remove the employer phone call requirement. Replace it with something like 'Return a call within a timely manner.' The employer should send someone in with the visit."*

  - *"The literature says that a call to the immediate supervisor who is truly vested is the best of return to work outcomes. If I have some tie in to a large local employer, then I know who to call. But most of the time you'll get someone else on the phone (not the immediate supervisor). Or you talk to a supervisor who doesn't care if this guy comes back or not. Is this metric really measuring the quality of the call? I agree that this should be taken out. This metric theoretically makes sense but the admin process is a nightmare."*

Recommendations: Keep the first two best practices, reconsider the employer phone call.

- Continue to include the best practice of requiring the ROA in two days.

- Continue to include the best practice of requiring the completion of an APF early in the claim. Position the APF as the main communication tool to help with coordinated care.
    - Consider encouraging providers to complete APFs at each visit and use the APF as the main communication tool between providers on the care team in addition to the employer.
    - Make it easier to share APFs with employers and other providers involved in the treatment of the patient. Investigate if there are ways that L&I can support electronic access to the APF so that all involved parties can retrieve it easily and see which is the most recent.

- Reconsider the call to employers as a requirement
    - Consider how to help facilitate the connection between providers and employers. Investigate ways in which L&I can leverage the contact information it has about employers in order to share it with providers.
    - Consider how to capture the spirit of the best practice while considering the difficulty of putting it into practice. For example, several providers recommended redefining the practice as being responsive to employer phone calls.

Qualifying criteria

L&I is considering requiring providers to have at least one of the following criteria to qualify for top tier status:

- Have a higher level of education or certification. For example, MDs/DOs, must have board certification, while ARNPs would need a specialty certification.
- Use Certified Electronic Medical Records Systems (EMR).
- Implement quality improvements in their practice (Lean, TQM, Standard).
- Accept complex claims for injured workers. A complex claim is currently defined as a claim that is not moving forward to resolution. For example, a claim that has poor opioid management or a failed surgery. It may have both medical and non-medical complexities.

Finding: All providers currently have one or more of the four criteria.

Both the survey and the focus group participants indicated that they have at least one of four qualifying criteria.

Out of 161 survey participants:

- 100% had at least one of the four criteria.
- 9% had only one of the criteria
- 17% had two of the criteria
- 35% had three of the criteria
- 39% had four of the criteria

Of the 25 focus groups participants:

- 100% had at least one of the four criteria.

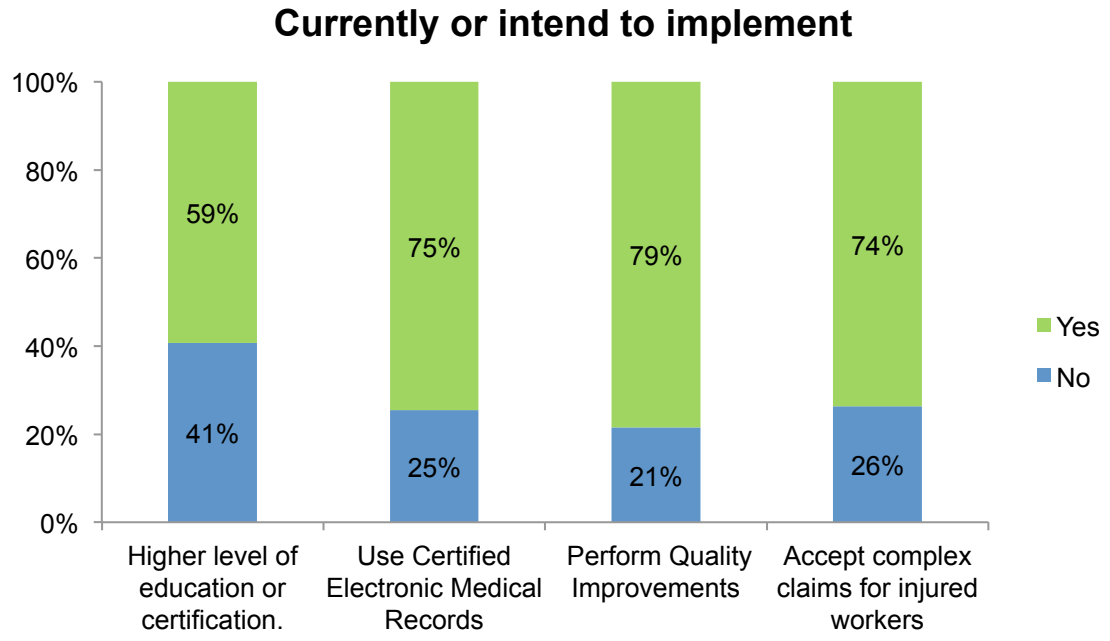


Figure 14. Survey responses: Qualifying criteria, participants who currently have or intend to implement (n=157)

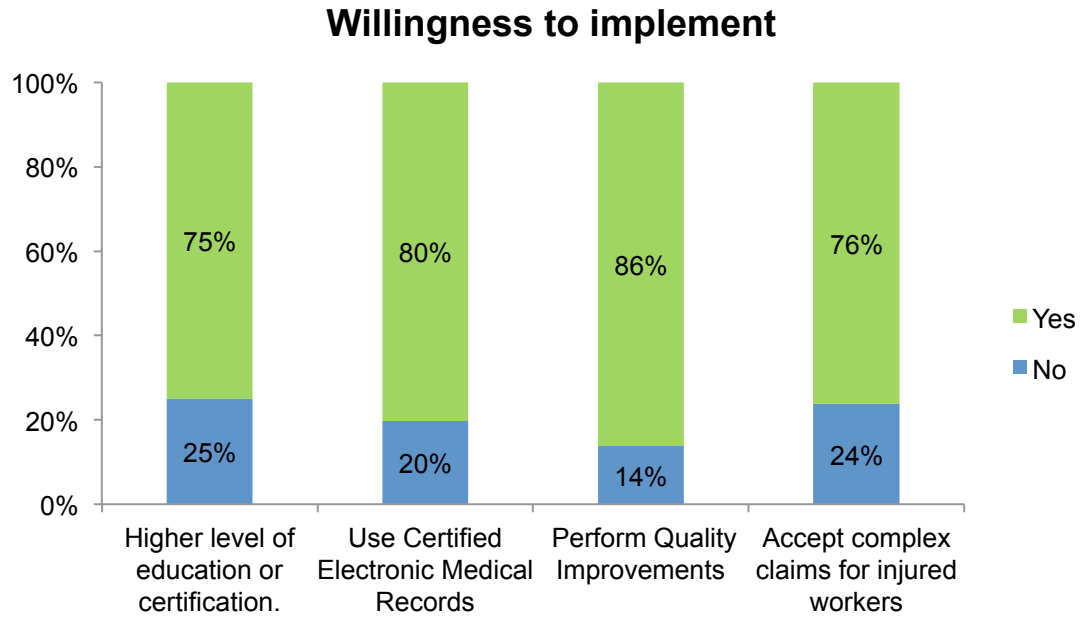


Figure 15. Survey responses: Qualifying criteria, participants who are willing to implement (n=156)

Finding: Some providers think the qualifying criteria should be more rigorous and more selective.

When considering the qualifying criteria collectively, some focus group participants felt that having to meet only one of the four criteria would prove too inclusive and therefore is not selective enough.

- One group recommended requiring both board certification and acceptance of complex claims, while EMRs and Quality would be optional additions.

Finding: Higher education, such as board certification, is seen as standard for MDs. Other types of providers were unsure how it applied to them.

- All MDs in the focus group had board certification and thought it should be a minimum requirement for top tier MDs.

- Specialty providers without board certification were unsure how this criterion would be applied to them.
    - The Naturopath and PA both indicated that there was no specialty certification for their field.
    - Chiropractors needed clarification on what was meant by higher level of education. Once they learned chiropractic consultants would qualify, some felt this was adequate. Other chiropractors did not feel that being a consultant was a high enough certification.

Finding: Most providers objected to using electronic medical records as a qualifying criterion for the top tier.

- The use of electronic medical records (EMRs) was a controversial topic in the focus groups. Several providers felt that this criterion alone would not suffice to qualify a doctor for the top tier.

    - *"I don't understand why EMR is on there. That eliminates small clinics. Just because you have EMR doesn't mean you know what you are doing, or result in quality or better outcomes."*

- Providers stated that although EMRs may allow for the sharing of information, there are issues about having systems talk to one another.

- Providers in smaller offices were concerned about the resource burden of adopting EMRs.

    - *"How does a one man shop do that? I can't afford an EMR."*

- Some providers stated that using EMRs does not necessarily lead to better outcomes. They explained that it could, in some circumstances, reduce the quality of care by relying on formulaic responses instead of good chart notes. Neatly written, dictated or typed notes were perceived as a better alternative.

- *"The EMR criteria is driven from L&I's efficiency perspective, shunting billing and notes. But chart notes in EMRs are formulaic and don't tell you much. They are the same thing over and over."*

- *"I don't think EMR is there yet, especially within occupational medical care. Throwing in EMRs really doesn't make a whole lot of sense. I've seen quality go down."*

- One provider suggested that the criterion could be about how legible or complete the chart notes were rather than if they were electronic.

  - *"Are the medical records legible? You should get something more useful such as type written full SOAPER notes as opposed to three scribbled notes. There must be some other way to judge the quality of communication."*

- Several providers who use EMRs appreciated the ways in which electronic systems had the potential to facilitate and therefore improve collaboration and communication.

  - *"I'd never go back to paper. It improves teamwork in your own office. You see the patient, and 10 minutes later everyone, including the billing person, has access. They can print it and there it goes."*

  - *"We use an EMR at [my large clinic]; it does improve care. If you are in [the clinic] and can see the record, then yes, it improves overall efficiencies."*

Finding: Most providers felt that performing quality improvement projects was reasonable, but not necessarily valuable as a qualifying criterion.

- Some providers consistently document quality projects as a requirement for recertification.

- Some providers felt that, prior to agreeing to this criterion, they needed more clarity from L&I on the requirements and documentation.

  - *"How are you going to rate us on quality improvement? How will you know or do you have the right to our interior workings?"*

Finding: Accepting complex claims should be required to qualify for top tier status. However, providers want freedom in determining which cases to accept.

- Accepting complex claims was seen as an important qualifying criterion. Providers in the focus groups believed that it is appropriate for top tier providers, with their experience and expertise, to handle complex cases.

  - *"[Top tier providers] have to see complex cases. You have to accept the full spectrum that comes at you. We are happy with the simple ones, but open and willing to accommodate of any kind of complexity."*

- Most providers in the focus groups currently accept complex claims and expect other top tier providers to do the same. Participants indicated that it would be unfair to qualify providers who only accept easy cases.

- *"If we're talking about the top tier, providers have to access the complex cases. If they are going to do three easy ones and they are done, they shouldn't be considered the top tier."*

- *"It isn't fair to penalize providers who take difficult cases over the years and then don't get the same outcomes."*

- While providers acknowledge the value of qualifying providers based on number of complex claims, they wanted to retain the ability to balance their panel of patients between complex and simpler cases.
    - Complex claims should be a portion of, but not a majority, of cases.
    - Providers never want L&I to force them to take a particular patient.
    - Providers want acknowledgement for taking complex cases. They do not want the fact that they take complex cases to lead to L&I penalizing them when evaluating the history of their claims.
    - Providers want extra support for claims that are hopelessly complex and have not moved towards resolution. They would prefer not to be stuck with these cases.

    - *"Complex claims are tough and a challenge. But if you have that skill set and want to employ it, you should. I like seeing difficult cases… but you don't want an office load of difficult cases."*

    - *"You get referrals from other doctors. I've done three back operations on a patient. They are a mess. I'm supposed to fix them. They are on high dose oxycontin, they continue to smoke. And I am supposed to wave my wand and get them back to work. I'd love to have someone to review the case, someone to help get them back to work. Tell me, how that's supposed to happen?"*

- Providers want the ability to communicate details to L&I that can help articulate the complexity of a claim.

    - *"Co-morbidity, obesity, they don't have private insurance … [It would be nice to have] a place to put the information."*

Recommendations: Streamline criteria to make top tier slightly more exclusive.

- Retain higher education or board certification. Continue to investigate alternative credentials for physicians' assistants, naturopaths and chiropractors.

- Require top tier providers to take a portion of complex claims.
    - Define the number or portion of claims that would be considered complex. Keep that number to a manageable portion.
    - Clearly define what L&I considers to be a complex claim.
    - Do not require providers to accept specific cases.

- Consider making the criteria related to EMRs and quality processes optional.

Potential incentives

L&I will use incentives to encourage providers to strive for top tier status. Initial incentives included the following:

- Financial incentives
- Easier medical management, such as easier or fewer authorizations
- Recognition for being in the top tier and having advanced expertise in treating injured workers
- Reliable single point of contact at L&I
- Access to a care coordinator outside of the providers' office to help with claims

In the survey, we asked providers to choose their top three incentives from a pre-defined list. While the majority chose financial incentives as their top choice, a significant number indicated that easier medical management, such as reduced authorizations and having access to a single point of contact at L&I were also highly valued.

In the chart below, we list the five top incentives from the survey, by role. Each incentive is labeled and marked by color to help show how the ranking differed by role.

	All	MD/DO	Podiatrists	Chiropractors	PAs	ARNP
	n=149	n=64	n=44	n=32	n=4	n=5
1	Financial incentives	Financial incentives	Financial incentives	Easier medical management	Access to a care coordinator	Financial incentives
2	Easier medical management	Easier medical management	Easier medical management	Financial incentives	Financial incentives	Recognition for being top tier
3	Reliable single point of contact at L&I	Reliable single point of contact at L&I	Reliable single point of contact at L&I	Reliable single point of contact at L&I	Reliable single point of contact at L&I	Easier medical management
4	Access to a care coordinator	Access to a care coordinator	Access to a care coordinator	Access to a care coordinator	Easier medical management	Reliable single point of contact at L&I
5	Recognition for being top tier	Recognition for being top tier	Recognition for being top tier	Recognition for being top tier	Recognition for being top tier	Access to a care coordinator

Figure 16. Highest ranked incentives, by group

In the focus groups, providers stated that they would find all of the incentives as motivations for applying. We explored the incentives in more detail. In this section, we capture the findings from the incentives discussion.

Finding: For some, financial reimbursement is a major incentive for gaining access to top tier status.

- Providers clearly articulated financial reimbursement as a major incentive for gaining top tier status. Many explained that better care requires more resources, and top tier providers should be compensated for this effort.
    - *"To adhere to these criteria would require more of my time, I'd have to pay more staff to manage these things. We need to be compensated for doing the extra work. It fiscally boils down to that."*
    - *"If you're performing well, pay should be better as a higher tier. Ideally, it would be 50% more, but should easily be 10-20% more than a regular tier provider."*

Finding: Non-financial incentives are actually financial incentives.

- While most providers favored some financial incentives, many emphasized that many types of incentives ultimately result in financial benefit. For example, fewer authorizations, a reliable point of contact at L&I and access to a care coordinator would increase efficiencies and result in saved time and labor without necessarily having to hire more staff.
    - *"If I received these incentives, my practice would become more efficient. We could work with more people, streamline our office operations and avoid hiring more staff."*
    - *"If this incentive translates into quicker authorizations, we'd be very motivated. We'd do anything not to have all the red tape."*

Finding: Strictly financial incentives do not appeal to all providers.

- For salaried providers, financial incentives are not personally motivating because those incentives are absorbed by the clinic and not the individual provider.
    - *"It doesn't matter to me. I work for a large clinic. Paying more doesn't mean much to me because I'll never see it."*
- Some providers felt that financial incentives could attract providers to the top tier for the wrong reasons, i.e., those who were solely interested in financial gain and therefore not motivated by doing the right thing for the care of the patient.
    - *"A financial incentive is a kick back. If the incentive to close the claim quicker, then some will just close [the claim] instead of helping the patient get better." – DPM*

Finding: Increasing efficiency and decreasing red tape makes providers and their staff more satisfied.

- Some providers agreed that the potential incentives, such as a single point of contact at L&I and streamlined authorizations would improve their practice in a way that would make the providers and their staff happier which would help them create a practice that is more satisfying to employees, physicians and patients.

- *"Improving medical management is important. If the office gets more money, that's fine. But if the staff is frustrated and not enjoying [working with L&I and injured workers] then it's too bad. The MAs get so frustrated with L&I and the calls."*

Finding: Recognition as an incentive is unnecessary, with the exceptions of generating new patients and finding other top tier providers.

- Several found the recognition piece superfluous. Others thought it was a nice gesture, but not as meaningful.
  - *"I don't need to pat myself on the back."*
  - *"I think acknowledgment, a little scroll to hang on your wall of shame, that would be nice."*
- Recognition that might translate into referrals is an important added value for practices seeking new patients and is beneficial. This was especially germane to chiropractors, podiatrists, and occupational medicine who see L&I patients as crucial to their business.
- Another benefit to some sort of visible recognition would be the ability for top tier doctors to easily identify one another for the purpose of referrals.
  - *"Recognition would help. Then you know who is providing that care and that helps the referral process."*
  - *"I get amazed at referral patterns [from one doctor to another]. They like the person, but they are not close or don't know what kind of work they do."*

Finding: Generating more referrals would be an incentive for some providers

- While some physicians do not need referrals or larger patient loads, many others indicated that it would be a worthwhile incentive.
  - *"You should add referrals to the list. If you could help me increase the number or referrals, we could see more patients, which would help our bottom line."*

Finding: Top tier providers want access to top tier claims managers.

When asked what other incentives would be compelling to them, providers emphasized that working with a good claims manager was key. They felt that the quality of the claims manager had an impact on the claim both in terms of their experience and being able to facilitate care for the worker. This finding was both strong in the survey data and all four focus groups. Providers felt that if L&I has a top tier program for providers, they should do the same for claims managers and pair up "top tier" claims managers with top tier providers.

- Giving providers expert claims managers was seen as a benefit that would give providers consistency in their dealings with L&I. The providers wanted access to a claims manager who trusts them to make decisions that are in the best interest of the worker. They also want claims managers to be easily accessible and

available.

  - *"A top tier claims manager would mean that L&I recognizes that I'm savvy. So I don't have to play the games and don't have to get the authorizations because they know I have a proven track record. When I call the CM, I want to say, you don't have to give me the hard time, I know what I'm doing. I'd put that as a number one incentive*."

- Providers interpreted the "single point of contact" incentive as a dedicated claims manager that they would develop a relationship with and use as an on-going resource.

  - *"Single point of contact, we should have one person to call the same claims manager"*

- Providers find dealing with the less competent claims managers frustrating and believe that they are often the ones stalling the cases.

  - *"I'd love to get through to a better claims manager – one who actually gets back to me in two days.*

  - *"Sometimes I'll see the name [of the claims manager] and think, oh no here we go. The claim is going to go sideways. They're going to send 20 letters asking for clarifying reports. I know my workload is going to increase. Some claims managers just get it. They know me and my work. They know I'm not going to ask for something crazy. Those ones are a delight to work with."*

Finding: Streamlined authorizations is an attractive incentive.

Providers are frustrated working with Qualis or having to call the department for authorizations. They see streamlined authorizations as a meaningful incentive.

- One focus group agreed that premier status to get authorizations fast tracked, nicknamed a gold card, would be a valuable incentive.

  - *"A gold card would indicate that L&I trusts our abilities - but they would still need to verify our performance. Maybe a gold card that lasts 1-2 years and then a provider could be re-evaluated."*

- Surgeons in Spokane talked about being frustrated by the amount of time they have to wait for an authorization and how it can delay treatment. They were not able to schedule surgery in a timely fashion due to the delays in authorization or they would have to schedule and then risk canceling due to hold ups with L&I.

Finding: Top tier providers should have access to an expanded formulary.

Some providers mentioned that the L&I drug formulary was limited, especially when it came to looking for alternatives for pain management.

- Providing more flexibility in prescribing could be a beneficial incentive.
    - *“There are good [pharmaceutical] products out there that aren't approved. Patients are purchasing them out of the their own pockets.” - chiropractor*
    - *“I don't want to make them sick first with other drugs. It would be nice to have a few more drugs without having to go through the process.” – occupational medicine*

Reflections on a top tier program

In this section, we provide additional findings, observations and recommendations related to the top tier program as a whole and how it would be implemented.

Finding: A top tier program would be beneficial and help to improve the workers' compensation system. Providers are interested in top tier, attracted by the incentives and say they would apply.

At the end of each focus group, we asked participants if they would apply to be part of the top tier. All 25 participants said they would, with some caveats.

- The two Seattle groups stipulated that they would apply to join top tier if the criteria were changed in some fundamental ways, namely removing or modifying the employer phone call.
- Some providers felt that the qualifying criteria should be more selective and not be too easy to get in to top tier.

Some providers went further than the existing criteria and suggested that specific measurable outcomes should be a consideration in terms of eligibility. For example, by measuring time loss and return to work.

  - *"Time loss measures how poor the pattern is going to be, the system, the employer, society. I believe if you look at top tier providers, time loss numbers going to be lower." – Occupational Medicine*

Observation: Some specialties have unique needs, constraints, and relationships.

Creating a top tier that is flexible enough to accommodate all of the L&I attending providers, yet rigorous enough to be seen as valuable may be a challenge.

Surgeons

We learned that surgeons, while eligible in terms of their roles as attending providers, are unique and not necessarily the same as other providers. Surgeons do not see themselves as leading the care coordination effort including communications with employers. They are interested in and willing to play a role in the coordination of care, but think an occupational medicine doctor should lead that coordination.

Surgeons see the role they play as fixing the injured worker and getting them back "on the field." However, the surgeons in our sessions wanted to be part of a top tier, they just didn't see how some of the criteria fit into their practice.

  - *"I want to be top tier, I don't want to be part of the B squad. That being said, there should be different categories of top tier. I can be an important part of the team. You guys (occupational medicine) should manage the process [of getting back to work and workers comp]. I'm not trained to do that. What would I want for my mom or wife, it's not me managing the process? It'd be more efficient and cost effective for [occupational medicine] providers." – Surgeon*

For surgeons, it may be beneficial to consider if they belong in the top tier program, which is geared to ongoing care, or if they would be better served by another best practice program, such as the Ortho/Neuro Pilot.

Chiropractors

Chiropractors are interested in becoming part of the top tier and see their role as integral to helping a worker return to work. However, some of the criteria, like having existing knowledge of opioid management, were seen as going beyond their current practice or domain. Chiropractors who came to the focus group sessions were open to learning more in this area. The participants in our groups seemed committed to L&I patients and saw their expertise as playing a vital role. Therefore, if L&I takes a broad view of the competencies and sees them more as opportunities for education, rather than testing of existing knowledge, it would be reasonable to include the opioid knowledge as a requirement. L&I should clearly communicate that knowledge in this area, especially for providers who don't prescribe opioids, is patient-centered and can help improve overall outcomes.

As the survey shows, Chiropractors tend to have smaller practices and therefore some of the requirements that involve investments such as a dedicated resource for care coordination or the adoption of an EMR may not be financially feasible for this audience.

Providers who tend to see more complex cases: Physiatrists and Psychiatrists

Most providers in the focus groups had experience with complex claims. However, some specialties tend to have a higher level of cases due to the type of medicine they practice. For example, both Physiatrists and Psychiatrists often have a larger portion of patients on their panel who have cases that are longer term and not easily resolved due to severity or complicating factors. While both of these specialties were supportive of the top tier network, there were questions about how the claim evaluation piece of the criteria would apply to them and account for these circumstances.

In terms of implementing the top tier, L&I should continue to consider how the criteria can be fairly applied to all, while taking in account the valid differences in specialties.

Recommendation: Make it easy to apply.

Due to providers' experiences with L&I and their impressions that the agency can be slow and bureaucratic, consider how to exceed their expectations in the execution of the top tier program.

We recommend:

- Clearly communicate the requirements and criteria.
- Make the application process easy and pain free.
- Make it easy to communicate with L&I regarding questions about the program.
- Be transparent and fair with the program implementation and communication.

Recommendation: Anticipate and avoid unintended consequences.

Some providers were concerned that the implementation of the program could result in unintended consequences that could either exacerbate the existing challenges of the workers' compensation system, incentivize particular practices, or unfairly reward undeserving providers.

For example, the providers agreed that it would not be fair to allow providers who only saw a few easy claims a year to be part of the top tier network. This was part of the motivation for the requirement that providers have patients with complex claims on their panel.

Providers did not want a top tier system that would reward claims processing at the detriment to the care of the injured worker. For example, one occupational medicine provider who had previously practiced in California reflected on how that top tier system there rewarded claim closing.

- *"One thing that I was thrilled to see, what is not on there, which is something to do with costs. Costs of the claims being minimized and/or cases closed promptly. L&I's literature is excellent about that. It's pro patient, and it gives us, theoretically, the tools, we need to manage the case. The reality is different. IMEs in my opinion are not thoughtful, seems like their primary objective is to close the case. Having been informed by my California experience, where a few of the insurance companies, the only way to get in their top tier need is to ignore the needs of the patient by minimizing your expenses, not going to surgery or giving permanent impairment. This [criteria] all seems fair and genuine and obviously we don't want to give the patient anything they don't deserve, but if we know the rules and follow the rules, we'd like it to be reflected." – Occupational Medicine MD*

Broader findings related to providers and L&I

In addition to the specific findings related to the top tier criteria, the research yielded several findings that are helpful to articulate the relationship between providers and L&I. These findings can help identify opportunities to improve and strengthen that relationship.

Values

When providers spoke of their experience with L&I and their reactions to the top tier, several values emerged as important to the relationship between providers and L&I.

Trust

Providers want L&I and claims managers to trust them to make the best medical decisions for patients. They want to be seen as trusted partners. Trust is more likely if the provider feels that the claims manager is attentive, respectful, and timely. The theme of trust came up especially when talking about authorizations, referrals and exceptions to the drug formulary.

- *"I have to submit paperwork to do the MRI to get approval. But who is going to know better than me?"*
- *"When you trust us and we can move ahead quicker."*
- *"[Belonging to the top tier means you are savvy so you don't have to play the games. You don't have to deal with Qualis. It means I have a proven track record."*

Fairness

Providers want L&I to create a system where they are treated fairly. Some providers were concerned that the top tier criteria might provide loop holes and create a system that rewarded providers who were not worthy of the designation. They were concerned about it being too inclusive of any provider. Providers wanted the top tier of the network to be meaningful.

- *"Make it mean something. If you don't exclude people it won't."*

Fairness also came up in regard to complex claims. Providers want L&I to take into account the constraints that providers face when they take on complex claims. They did not want to be unfairly penalized or judged for other providers' decisions that may have led to a claim becoming complex. They also wanted L&I to acknowledge the role the injured worker played in his or her recovery.

Transparency

Providers felt that L&I should be more transparent. Transparency was implied in several ways. First, providers want L&I and claims managers to clearly communicate what they need. Second, they wanted more access to claim history, previous decisions, and authorizations. Third, some providers thought L&I should share information about injured worker outcomes that would help the providers improve their practice.

- *"If there is a way to way get transparent to see the process. To see if there are patterns with a particular patient. You are weeks into [a claim] and you're blind. Then you get on the web site, to see if it was determined or denied. It's incredibly helpful [to see what's going on with the claim]."*

Current frustrations with the workers' compensation system and L&I

Finding: Applying to be part of the Provider Network is time consuming and frustrating.

One occupational medicine provider shared with us that her office staff had recently gone through the process of applying for the new L&I provider network. She mentioned it was slow and required a great deal of paperwork. This provider had hoped that the top tier application process would not be as cumbersome and time consuming.

- *"If the top tier program is like [applying to the network] and the paperwork is too burdensome I'm not going to bother" – Occupational Med doctor*

Finding: Emergency Departments are slow at completing and submitting the ROA, which impacts patient care.

Several providers mentioned the ongoing problem of Emergency Departments not submitting the ROA in a timely manner. This frustrates attending doctors, delays patient care and sometimes impacts the providers being able to get paid for their services. The providers encouraged L&I to look for ways to solve this problem.

Finding: Transferring care is slow and the process is unclear.

Attending providers mentioned the transfer of care process is slow. They thought claims managers should be quicker to respond to transfer requests. They mention that sometimes the transfer of care card they send is not noticed or acted on by the claims managers.

- *"The transfer of care form should be done in two days by the claims manager."*

Providers who are an attending provider for a limited amount of time were unclear on the transfer of care process. This was true for the surgeons in the group. They mentioned that they had attempted to refer patients to an occupational medicine specialist who could see the patient for ongoing care after surgery, but L&I would often

deny this request. They were not familiar with the transfer of care process.

Finding: There is a lack of information about structured settlements.

One provider was concerned that L&I has not provided information about the structured settlement program. He mentioned that the only information he has received about it has been from attorneys. He would like to know more so he could help patients if they are faced with that decision.

- *"Why is L&I not talking about structured settlement? How are you processing structured settlement? Why can't you advise me? I have no dog in that fight. Structured settlement only pays 15%. Why aren't you using us as a resource [to talk to injured workers]? I'm finding more about structure settlement from attorneys."*

Online interactions and services

Finding: The Claims & Account Center is a valuable tool, for those who have access.

- Providers who use the Claim & Account Center appreciate the visibility into the claim. It is a key resource for providing insight into the claim and it can help with care coordination. However, not all are in the system and others only have limited access.
  - *"It's great to go on the SAW website to see what's going on. Great tool."*
  - *"As an ancillary provider we don't have access to the records [in the Claims & Account Center]. As the chiropractor, I see the patient four times as much but don't have access. We should be able to get all the records. Otherwise I'm on the phone all time and bugging the doctors."*

Finding: Filing an ROA online is attractive to some, daunting to others.

- Some providers in the focus group are already using FileFast to file their ROAs online and mentioned that it was useful for getting the ROA filed in two days.
- Some other providers were interested in the prospect of filing online.
- Some thought that filing online might be difficult or complicated if it didn't talk to their existing systems.
  - *"We have our own EMR it's a pain enough to open our stuff and do it twice. I'm loath to open another system, which may or may not be available."*

Additional observations and recommendations

Observation: Coordinating care is difficult because the players are unknown or difficult to reach.

As reported above, providers, especially in the Seattle focus groups, talked about the difficulty of reaching the employer. It would be helpful to consider what role L&I could play to facilitate the connection between all the parties involved in the claim. This could include giving more accurate contact information for the employer to the provider, connecting the attending provider with ancillary providers, and sharing claim information with all parties in a way that was convenient and secure.

One provider talked about how she had to build her own network of trusted providers she could refer to and coordinate care with. L&I could investigate how these informal connections work and seek to implement them more broadly.

Observation: There are key differences between Eastern and Western Washington providers.

We conducted focus groups in both Eastern and Western Washington in order to gather feedback from a diverse set of providers. We did note some key differences in the sessions. Part of the differences could also be attributed to the fact that in the Spokane focus groups, all of the providers were part of a COHE whereas in Seattle most doctors were not and many had not heard of COHEs.

Some key differences we observed:

- In regards to the employer phone call, Eastern Washington providers were more likely to say that it was reasonable. These providers tended to have closer ties to employers and existing relationships. In the Seattle focus groups, the providers often cited that it was difficult to contact large companies without knowing where to begin to find the right person to talk to.
- In addition, the Western Washington providers seemed less likely to have close ties with other providers unless they were part of a larger clinic. In Eastern Washington, because of the smaller numbers, the providers seemed to know each other and other providers in the area which could streamline facilitation of care.

Recommendation: Give providers more insight into the claim by supporting access to online systems like the Claims & Account Center.

- Continue to promote and market the Claims & Account Center to providers who are not using it.

- Consider providing online resources that can assist with coordinating care.
    - For example, give providers an accurate, up to date contact name and phone number for the employer.
    - Consider more robust online tools such as expanding secure messages to accommodate multi-party conversations between the claims managers, providers and employers.

- Consider giving ancillary providers in the top tier, like Chiropractors or Surgeons, more access to the claim in the Claims & Account Center. Allow them to automatically have access to the claim even if they are not the attending.

Conclusions

In conclusion, providers who participated in the research were interested in the concept of a top tier network. Overall, the draft criteria were positively received and most providers agreed that they were reasonable, feasible, and lead to better outcomes for patients. The top tier network could be an opportunity to create a closer and more collaborative relationship with providers and ultimately improve the care of injured workers.

For the top tier to be successful, we conclude with some final recommendations.

- The criteria should be clear, concise and easily communicated.

- The application or sign up process should not be overly complex.

- Positioning the top tier as an opportunity to continue to build expertise could be compelling to some providers. Providers interested in top tier are also interested in learning more about occupational medicine.

Appendix A: Survey

Welcome!

In order to provide injured workers with the best possible care, L&I is establishing a new Provider Network. A feature of this new network is that medical providers who use best practices in occupational health will be awarded "top tier" status. We are developing criteria for how providers will qualify for the top tier and we need provider feedback. We are still exploring how to qualify providers for the top tier network. In this survey, we are interested in what you, as an L&I provider, think about the following:

Are the best practices L&I is considering something you currently do or are interested in doing?

Would you be interested in becoming part of a "top tier"?

What would entice you to join the "top tier"?

This short survey should take you 9 minutes to complete.

---

1. Have you heard about the new L&I Provider Network?

   ( ) Yes
   ( ) No

Section 1: About you

2. Are you enrolled in a Center of Occupational Health and Education (COHE?)

   ( ) Yes
   ( ) No

3. What is your role or title?

   ( ) Administrative staff (Biller, office manager, receptionist or other staff) **Disqualify**
   We are looking for feedback specifically from MD/DOs, chiropractors, ARNPs and physicians assistants. If possible, please share this survey with these personnel in your clinic. Thank you for your time.
   ( ) MD/DO
   ( ) DPM
   ( ) Chiropractor
   ( ) Advanced Registered Nurse Practitioner (ARNP)
   ( ) Physician's Assistant
   ( ) Nurse (RN, LPN) **Disqualify**
   We are looking for feedback specifically from MD/DOs, chiropractors, ARNPs and physicians assistants. If possible, please share this survey

with these personnel in your clinic. Thank you for your time.

( ) Other: _____

4. What is your specialty?_____

•

5. How many injured workers do you treat each month?

( ) Less than 1

Thank you for your feedback! To learn more about the top tier provider network, please visit our Provider Network page at www.providernetwork.lni.wa.gov.

( ) 1 - 5
( ) 6 - 11
( ) More than 1

6. How many providers are in your practice?

( ) 1-5 providers
( ) 5-20 providers
( ) over 20 providers

Section 2: Current practices related to L&I patients

Here are three best practices we've already identified; in a minute we'll be asking you about some others that we are considering:

- Submit the Report of Accident to L&I within 2 business days.
- Complete an Activity Prescription Form (APF) early in the claim
- Make a phone call to the employer to discuss return to work early in the claim

•

7. Does your practice currently submit the Report of Accident to L&I within 2 business days?

( ) Never
( ) Sometimes
( ) Always
( ) I don't know

8. Please answer the following question about: Submit the Report of Accident to L&I within 2 business days.

	Yes	No
Does this best practice seem reasonable?	( )	( )
Do you think this best practice is related to improved outcomes?	( )	( )
In your workplace, is this best practice feasible?	( )	( )

9. Does your practice currently complete an Activity Prescription Form (APF) early in the claim?

   ( ) Never
   ( ) Sometimes
   ( ) Always
   ( ) I don't know

10. Please answer the following questions about: Complete an Activity Prescription Form (APF) early in the claim

	Yes	No
Does this best practice seem reasonable?	( )	( )
Do you think this best practice is related to improved outcomes?	( )	( )
In your workplace, is this best practice feasible?	( )	( )

11. Does your practice currently make a phone call to the employer to discuss return to work early in the claim?

    ( ) Never
    ( ) Sometimes
    ( ) Always
    ( ) I don't know

12. Please answer the following questions about: Make a phone call to the employer to discuss return to work early in the claim

	Yes	No

Does this best practice seem reasonable?	( )	( )
Do you think this best practice is related to improved outcomes?	( )	( )
In your workplace, is this best practice feasible?	( )	( )

Section 3: Knowledge and Performance

L&I hopes that creating a network of top tier providers will improve outcomes for injured workers. We are considering some of the following areas to evaluate best practice providers, and value your opinions.

- Care Coordination-having a resource to make sure the treatment plan (both clinical and return to work) is complete and ensuring follow through by all members of the care team. The care team includes consulting providers, ancillary providers, claim managers, vocational staff, employers, etc.
- Collaboration & Communication-making sure that all members of the care team have the information they need to provide the best possible care for the patient. This includes being responsive to requests for information from team members who are not clinical providers, such as the employer, vocational counselor, or claim manager.
- Workers Comp- being familiar with the rules and processes in the Washington State workers' compensation system.
- Opioid Management- understanding appropriate use of opioids and alternatives for pain management.
-

13. Please rate your current knowledge in the following areas (1 being low and 5 being high)

	1	2	3	4	5
Care Coordination	( )	( )	( )	( )	( )
Collaboration & Communication	( )	( )	( )	( )	( )
Workers Comp	( )	( )	( )	( )	( )
Opioid Management	( )	( )	( )	( )	( )

14. In your opinion, could L&I measure a provider's knowledge in each of the areas below?

	Yes	No
Care Coordination	( )	( )
Collaboration & Communication	( )	( )
Workers Comp	( )	( )
Opioid Management	( )	( )

15. In your opinion, would reviewing a sample of claims give L&I a reasonable measure of a provider's performance in each of the areas below?

	Yes	No
Care Coordination	( )	( )
Collaboration & Communication	( )	( )
Workers Comp	( )	( )
Opioid Management	( )	( )

16. Would an injured worker have better clinical or return to work outcomes if their provider demonstrated best practices in each of the areas below?

	Yes	No
Care Coordination	( )	( )
Collaboration & Communication	( )	( )
Workers Comp	( )	( )
Opioid Management	( )	( )

Section 4: Qualification criteria

17. We are considering qualifying providers who: have a higher level of education or certification.

	Yes	No
Does this best practice seem valuable?	( )	( )
Do you currently do or intend to implement this practice?	( )	( )
Would you be willing to implement this practice?	( )	( )

18. We are considering qualifying providers who: Use Certified Electronic Medical Records

	Yes	No
Does this best practice seem valuable?	( )	( )
Do you currently do or intend to implement this practice?	( )	( )
Would you be willing to implement this practice?	( )	( )

19. We are considering qualifying providers who: Perform Quality Improvements

	Yes	No
Does this best practice seem valuable?	( )	( )
Do you currently do or intend to implement this practice?	( )	( )
Would you be willing to implement this practice?	( )	( )

20. We are considering qualifying providers who: Accept complex claims for injured workers

	Yes	No
Does this best practice seem valuable?	( )	( )
Do you currently do or intend to implement this practice?	( )	( )
Would you be willing to implement this practice?	( )	( )

21. Do you have additional comments or thoughts related to the qualification criteria above?

Section 5: Incentives

22. L&I is exploring what incentives would encourage providers to join the top tier.

    Please rank your top two preferred incentives from the list below.

_____Financial incentives

_____Easier medical management, such as easier or fewer authorizations

_____Recognition for being top tier and having advanced expertise in treating injured workers

_____Reliable single point of contact at L&I

_____Access to a care coordinator outside of your office to help with claims

23. Please comment on other incentives that would encourage you to join the top tier.

24. Would you be willing to participate in future L&I research on the top tier?

    ( ) Yes

    Please provide your contact information.

    First Name: _____

    Last Name: _____

    Email Address: _____

Phone Number: _____

( ) No

Thank You!

Thank you for your time and attention in responding to this questionnaire, including your bringing it to the attention of others in your workplace. If you have questions about this study or its results, the L&I contact person for this study is: Noha Gindy, ginn235@LNI.WA.GOV, 360-902-6564.

Appendix B: Focus group discussion guide

Introductions and background: 10

- What is your name?
- Tell us about the practice you work in: Type, size, location, etc.
- Tell us about treating injured workers: how many, types of common injuries
- Unique or fun fact about you. Tell us about the most unique place where you have practiced medicine

Introduction to the concept of Top Tier: 10

In 2011, Washington state lawmakers approved workers' compensation reform (Substitute Senate Bill 5801). Part of this reform mandated that L&I establish a new Provider Network, including a "top tier" designation for medical providers who use occupational health best practices. We are developing eligibility criteria and we need provider feedback. In this focus group, we are interested learning more about:

- Are the top tier criteria L&I is considering something you currently do or are interested in doing?
- Would you be interested in becoming part of a top tier?
- What incentives would be appropriate for the top tier?

I. Assessing Provider Core Competencies: 20

We are considering the following four core competencies to assess providers for the top tier:

Care Coordination: having a resource to make sure the treatment plan (both clinical and return to work) is complete and ensuring follow through by all members of the care team. The care team includes consulting providers, ancillary providers, claim managers, vocational staff, employers, etc.

Collaboration & Communication: making sure that all members of the care team have the information they need to provide the best possible care for the patient. This includes being responsive to requests for information from team members who are not clinical providers, such as the employer, vocational counselor, or claim manager.

Workers Compensation: being familiar with the rules and processes in the Washington State workers' compensation system.

Opioid Management: understanding appropriate use of opioids and alternatives for pain management.

We are considering evaluating each of the core competencies in **two ways**:

- Testing existing knowledge
- Evaluating a number of claims treated by the provider

Questions:

1. Is it reasonable to expect top tier providers to have knowledge in each of these four areas?
2. Do you think providers with these competencies will have better claim outcomes?
3. What are the challenges of acquiring these competencies in your practice?
4. Are there alternative competencies that would be a better option for assessing providers?
5. What are your thoughts on the evaluation of these competencies
    a. Testing
    b. Claim evaluation

II. Best practices: 20

L&I has identified three occupational health best practices:

- Submit the Report of Accident to L&I within 2 business days
- Complete an Activity Prescription Form (APF) early in the claim
- Make a phone call to the employer to discuss return to work early in the claim

Note: according to our survey research the third item seems to generate the most concern for providers. If time is limited, vote first on all three then discuss employer phone call in depth.

Report of Accident (ROAs)

Let's talk about ROAs:

1. How many of you complete ROAs on a regular basis? (Yes/No Voting Card)
2. If you do submit ROAs, how many of you submit your ROA to L&I within 2 business days?

Discussion Ideas:

- Does this best practice seem reasonable to you? (Yes/No Voting Card)
- Do you think this would lead to improved outcomes?
- What do you think are the challenges to doing this in your practice?

Activity Prescription Form

Let's talk about APFs: (participants use voting cards)

- How many of you regularly use the APF? (Yes/No Voting Card)

Discussion Ideas:

- Does this best practice seem reasonable to you? (Yes/No)
- Do you think this would lead to improved outcomes?
- What do you think are the challenges to doing this in your practice?

Calling Employers

Let's talk about calling employers after seeing an injured worker: (participants use voting cards)

- How many of you regularly call an employer early in a claim to discuss return to work?

Discussion Ideas:

- Does this best practice seem reasonable to you?
- Do you think this would lead to improved outcomes?
- What do you think are the challenges to doing these in your practice?

Follow up:

- When considering the three best practices as a package, do they seem like a reasonable group?

III. Additional Qualifying Criteria: 15

To qualify for top tier, we are considering criteria that would ask a medical provider to have one of the following:

- Have a higher level of education or certification. For example for MDs/DOs, board certification and for ARNPs, specialty certification.
- Use Certified Electronic Medical Records Systems
- Implement quality improvements in your practice (Lean, TQM, Standard)
- Accept complex claims for injured workers. A complex claim is currently defined as a claim that is not moving forward to resolution. For example, a claim that has poor opioid management or a failed surgery. It may have both medical and non-medical complexities.
-

Do you currently do at least ***one*** of these four criteria?

Let's talk about each one separately:

1. Do you have a higher level of education or certification?
2. Does your practice use a certified electronic medical records system?
3. Does your practice use and document quality improvement projects?
4. Do you current accept complex claims?

Discussion Ideas:

1. Would you be willing to adopt one of these four criteria to qualify?
2. How would adoption of one of the criteria impact your practice?

3. What are the challenges of adopting one of the criteria?
4. Do you think these are reasonable criteria?

IV. Potential Incentives: 20

(15 minute sticky-note exercise)

L&I will use incentives to encourage providers to strive for top tier status.

We are considering the following. What are others that would be compelling to you?

- *Financial Incentives*
- *Easier medical management, such as easier or fewer authorizations*
- *Recognition for being top tier and having advanced expertise in treating injured workers*
- *Reliable single point of contact at L&I*
- *Access to a care coordinator outside of your office to help with claims)*
- *Others*

Follow ups:

1. *What is frustrating about working with L&I, what could we do to make it easier?*

V. Wrapping up: 05

Let's wrap up by voting overall on what we think of the top tier criteria.

1. If we moved forward with the criteria as is, how many of you would apply?
2. If we modified the criteria to include (x,y,z) how many of you would apply? What are your must haves/deal breakers?
3. Anything else you'd like to share?

Thank you for attending. In appreciation of your time, we have an honoraria to offer to thank you for participating.

Appendix C. Survey confidence intervals and margins of error

We have conducted confidence intervals to ensure rigor in our findings. The sample size of the survey was 184 out of a population of approximately 17,000. This sample was appropriate for this research and we are confident that it allows us to generalize to the larger population of attending providers.

In this section, we provide details of the confidence intervals and margin of error on a subset of the survey questions.

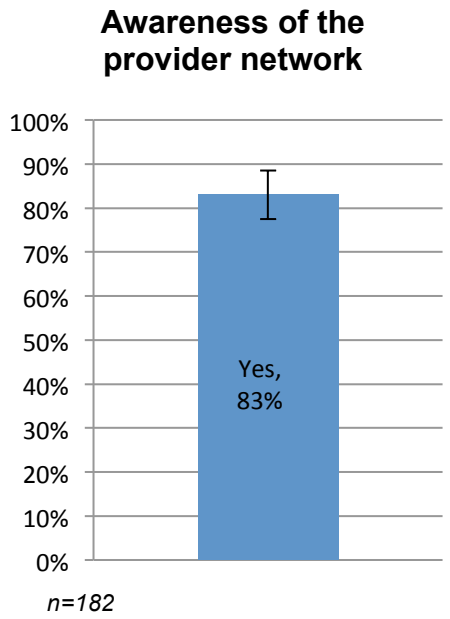


Figure1. We can be 95% confident that awareness of the provider network is between 77% and 88%.

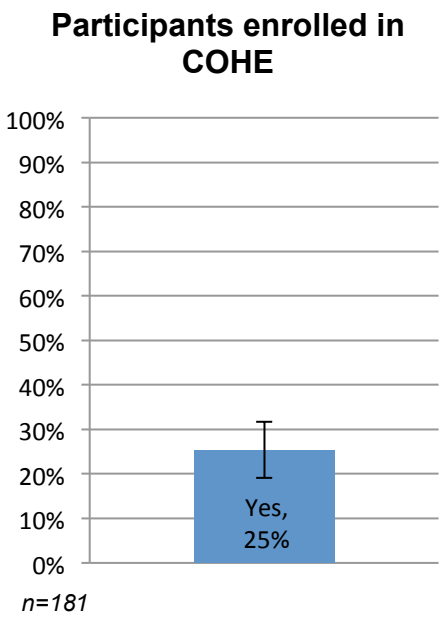


Figure 2. We can be 95% confident that participants enrolled in COHE is between 20% and 32%.

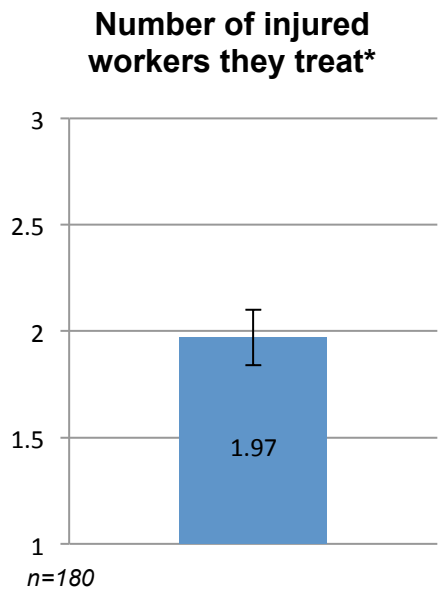


Figure 3. We can be 95% confident the population means is between 1.83 and 2.10.

**Converted injured worker scale to:1-5 =1; 6-11 = 2; More than 11 = 3*

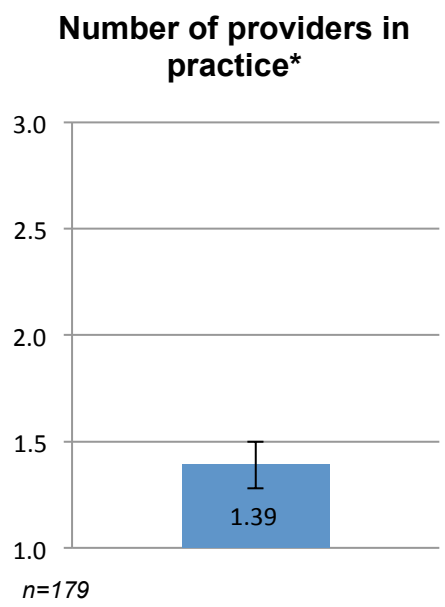
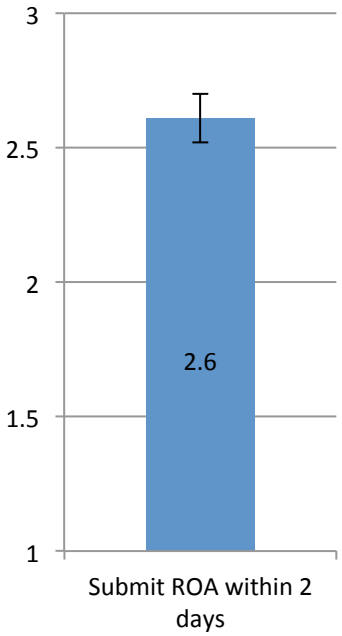


Figure 4. We can be 95% confident that population mean is between 1.28 and 1.49.

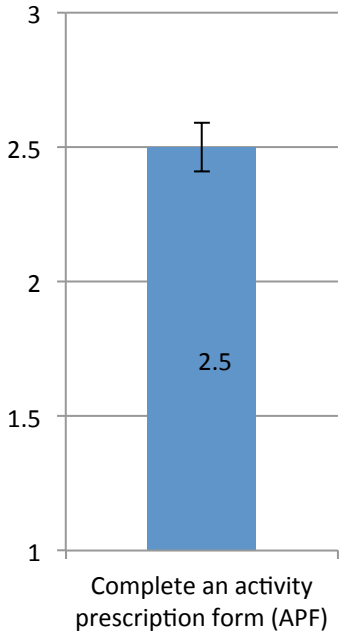
**Converted scale to:1-5 providers =1; 5-20 providers = 2; Over 20 providers = 3*

Current Best Practices*



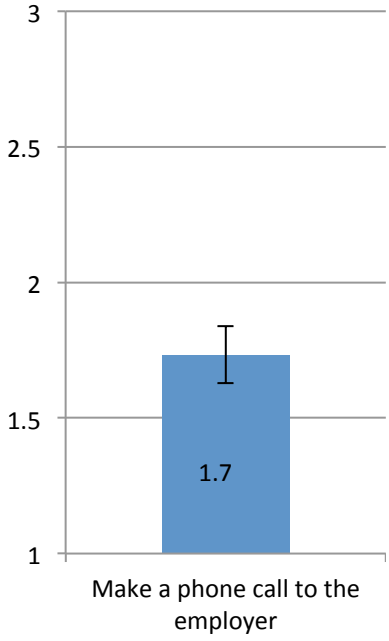
n=148

Figure 4. We can be 95% confident that population mean is between 2.52 and 2.70.



n=162

Figure 5. We can be 95% confident that population mean is between 2.41 and 2.59.



n=161

Figure 6. We can be 95% confident that population mean is between 1.63 and 1.84.

**Converted scale to: Never =1; Sometimes = 2; Always = 3, did not include respondents that did not know*

Below are 95% confidence intervals of reported existing knowledge of the core competencies. The margin of error for all competencies but opioid management was approximately 4%.

Table 1. Existing knowledge of core competencies (1 low to 5 high)

	Sample Size (n)	Mean	Standard deviation	Margin of error	Marg in	Confidence Interval
Care Coordination	161	3.86	1.00	4.03%	0.16	3.70-4.01
Workers Compensation	161	3.94	1.00	3.95%	0.16	3.79-4.10
Collaboration and Communication	161	3.86	1.02	4.12%	0.16	3.70-4.02
Opioid Management	156	3.56	1.40	6.23%	0.22	3.34-3.78

Below is a table of 95% confidence intervals on the proportion of respondents that would be willing to implement the qualifying criteria. The margin of error ranged between 7%-8%.

Table 2. Currently or intend to implement

	Sample Size (n)	Proportion willing to implement qualifying criteria	Adjusted proportion	Margin of error	Confidence Interval
Higher level of education or certification	157	59%	59%	8%	51% -67%
Use Certified Electronic Medical Records	157	75%	74%	7%	67% - 81%
Perform Quality Improvements	149	79%	78%	7%	71%-84%
Accept complex claims for injured workers	152	74%	73%	7%	66%-80%

Appendix D. Core competencies

The following section shows survey data from each question by aggregate and by role.

Rating of existing knowlege

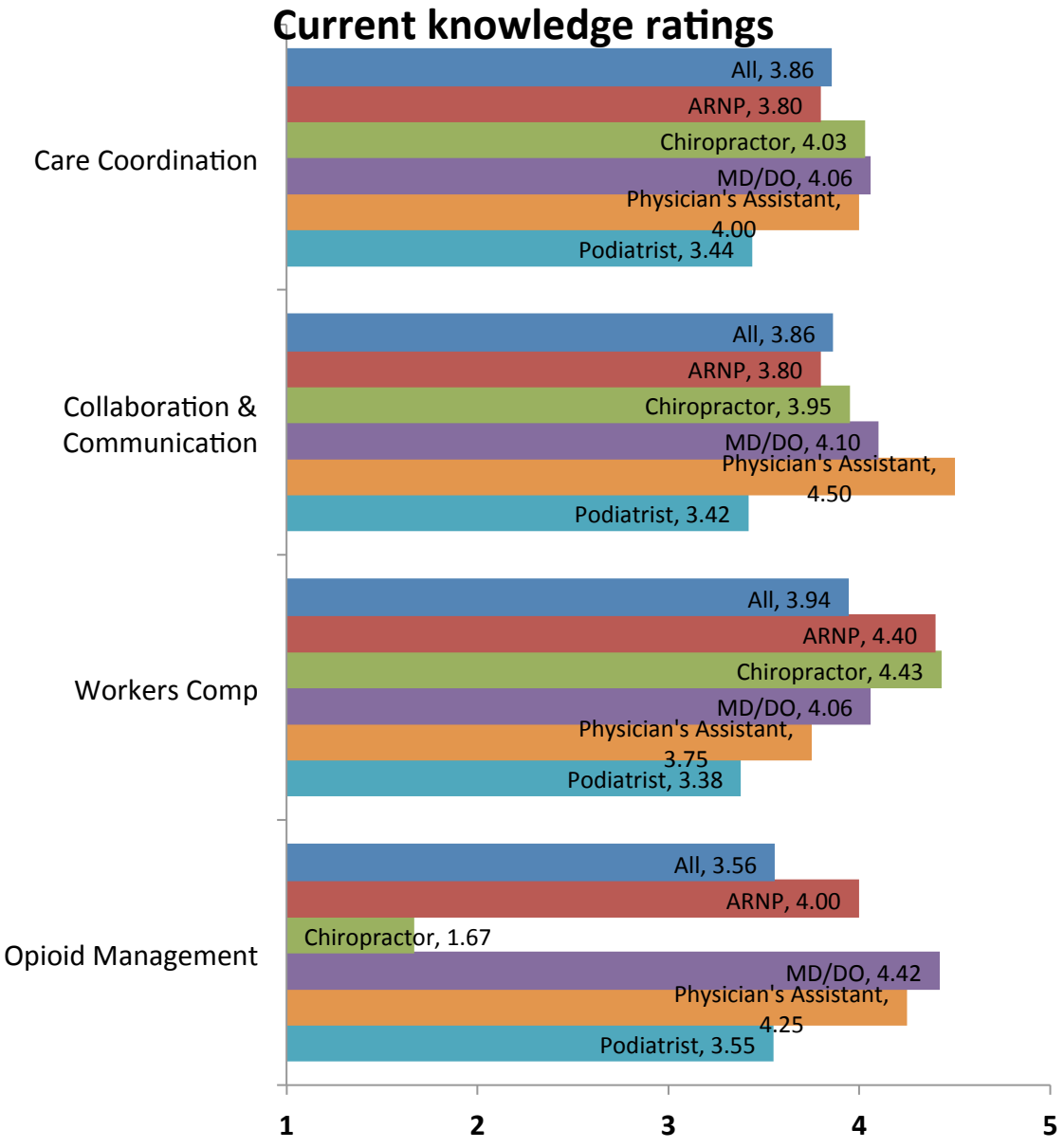


Figure 17. Knowledge of the core competencies

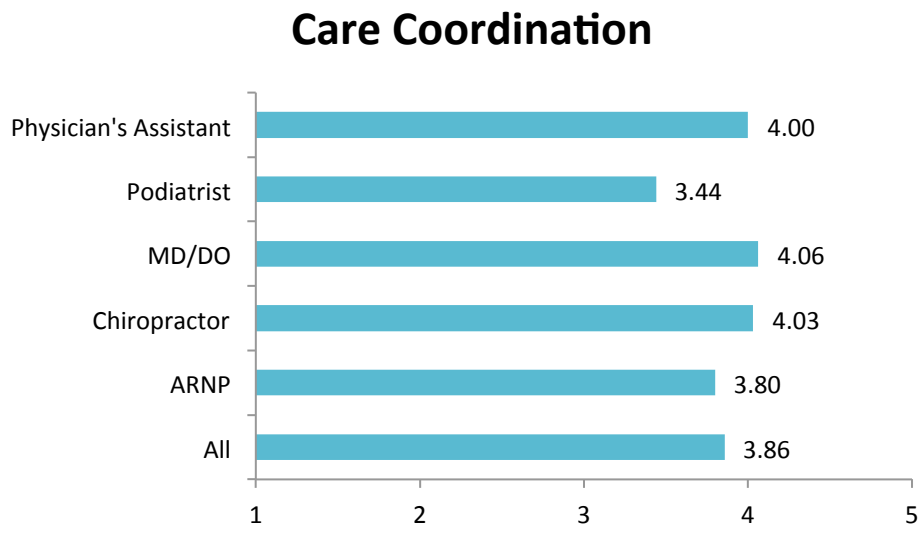


Figure 18. Knowledge of care coordination, by role

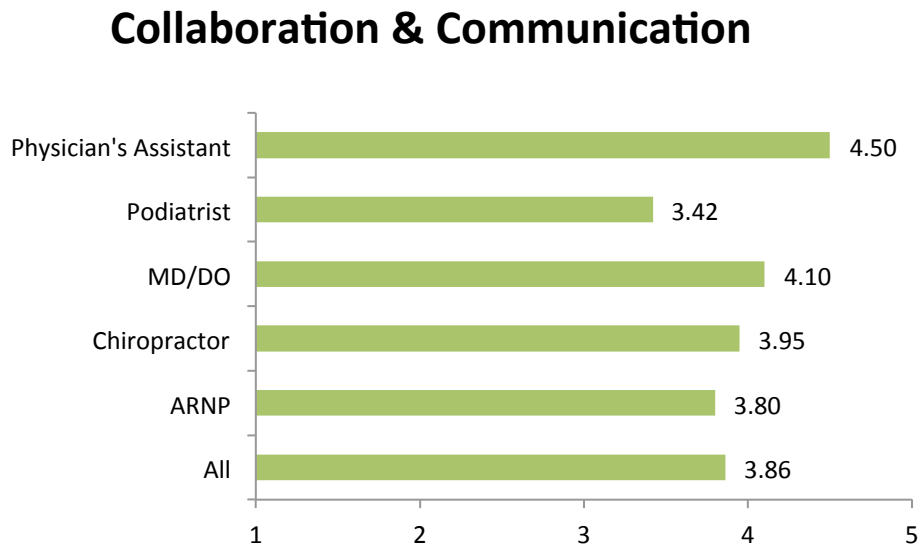


Figure 19. Knowledge of communication & collaboration, by role

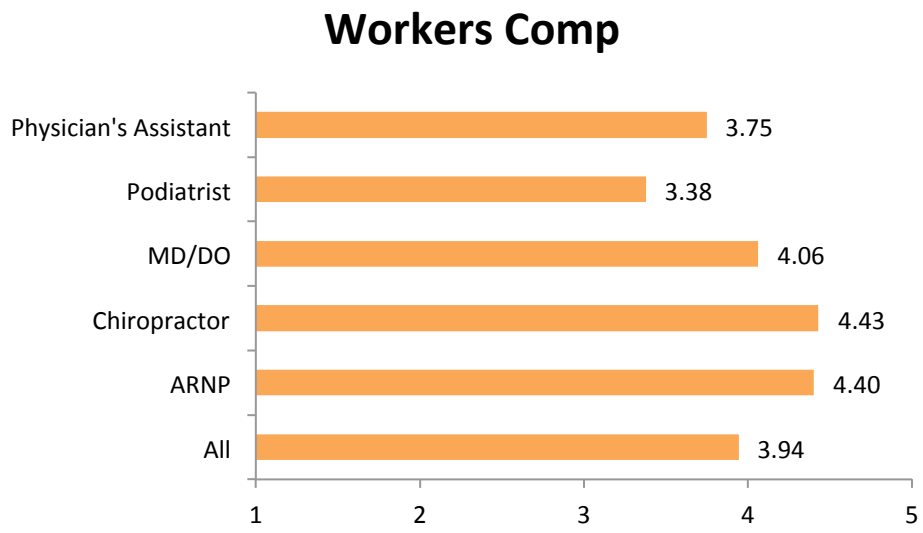


Figure 20. Knowledge of workers comp, by role

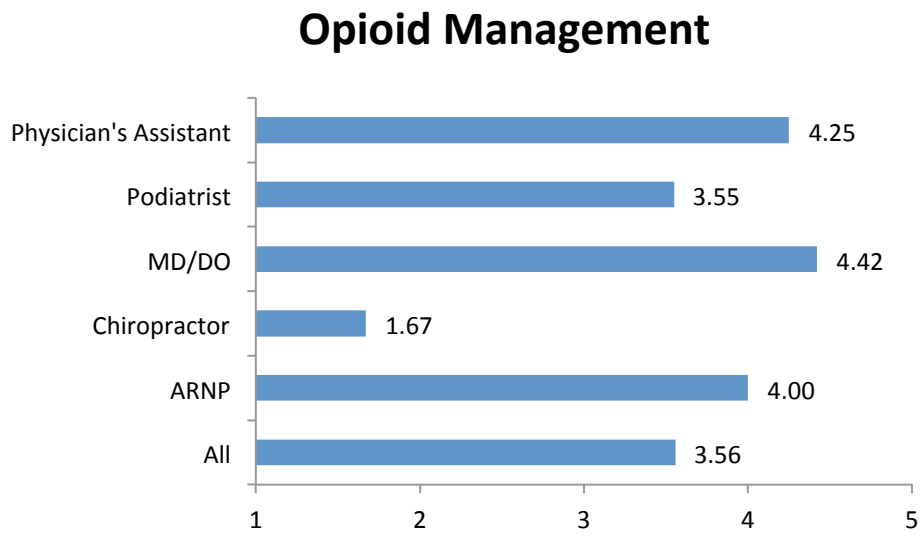
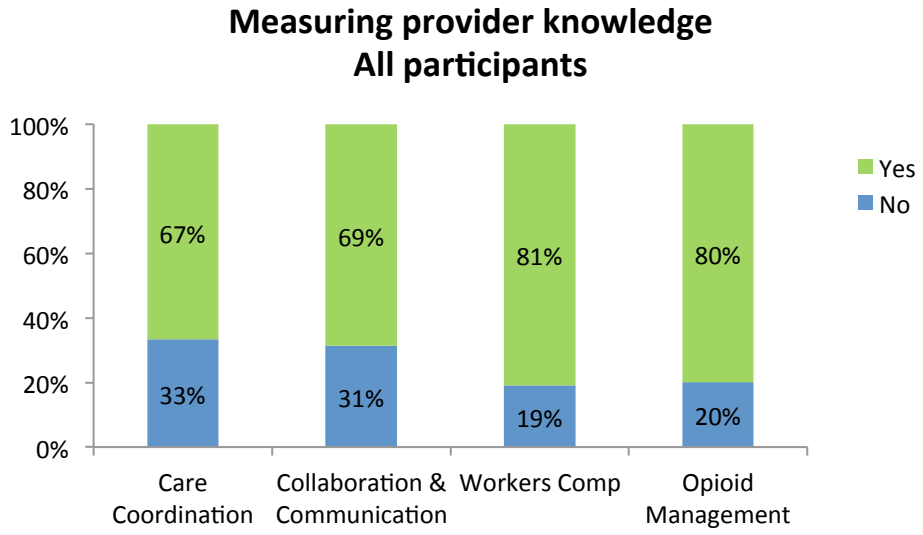
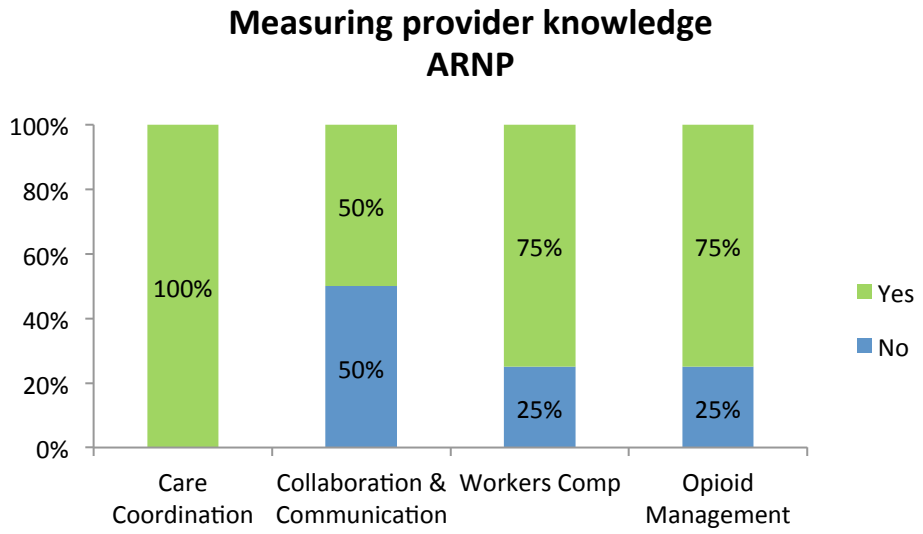
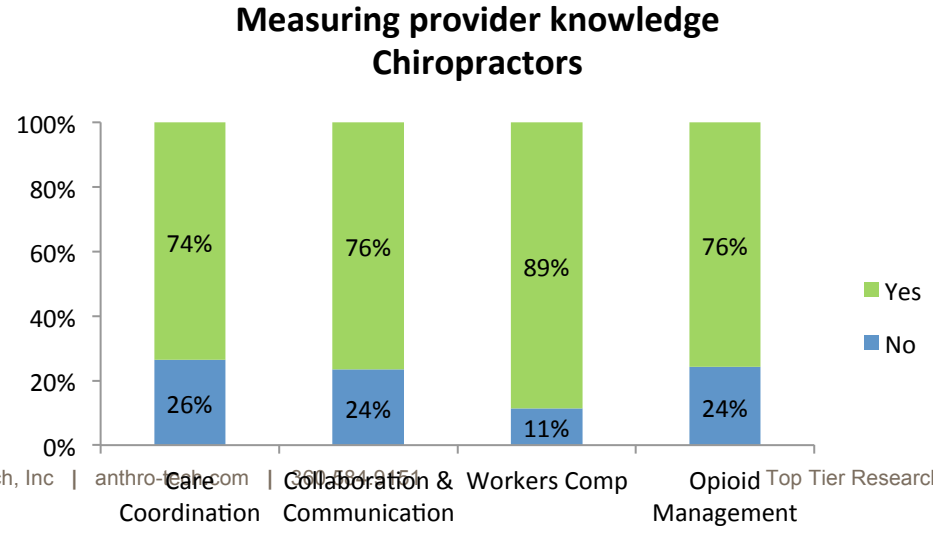


Figure 21. Knowledge of opioid management, by role

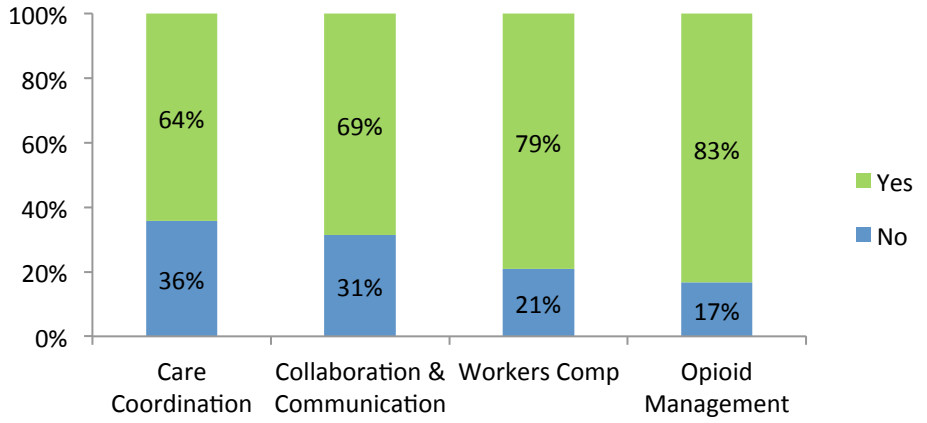
Measuring existing knowledge



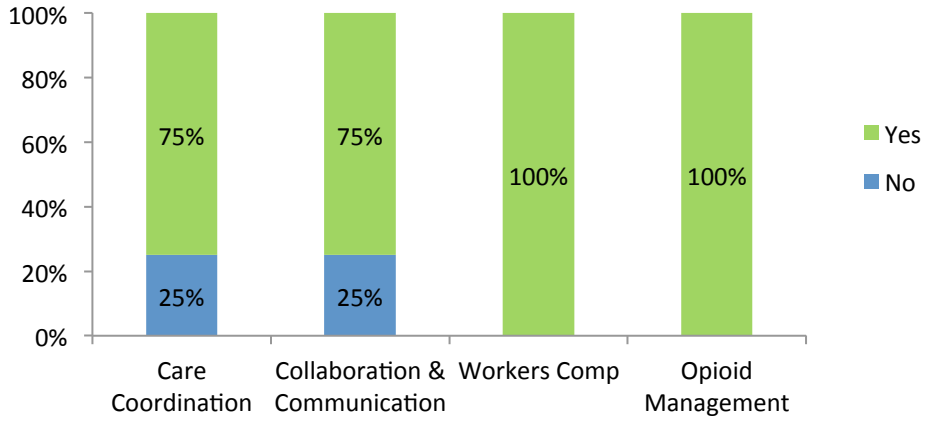




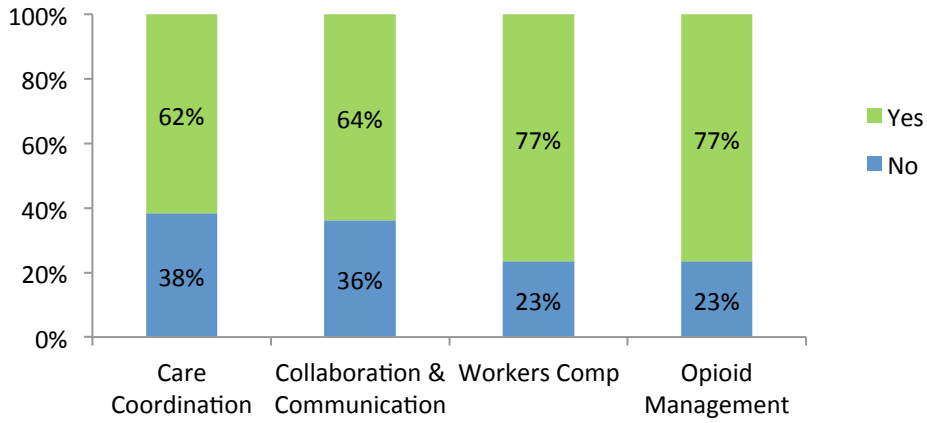
Measuring provider knowledge
MD/DO



Measuring provider knowledge
Physician's Assistants

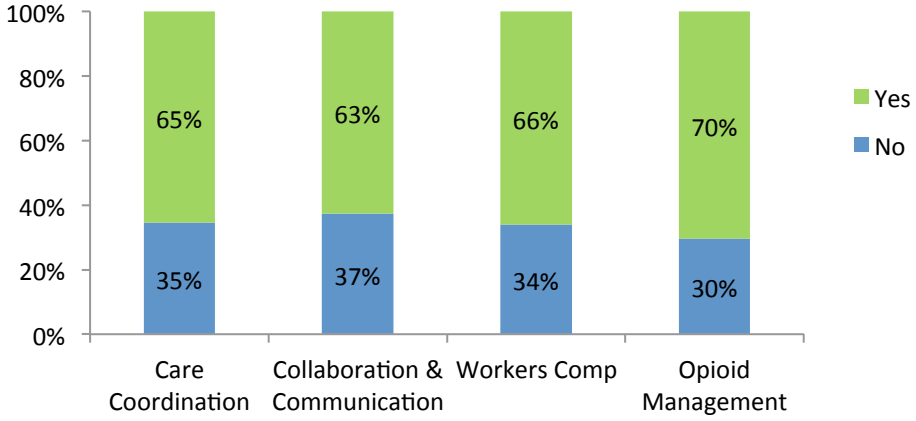


Measuring provider knowledge
Podiatrists

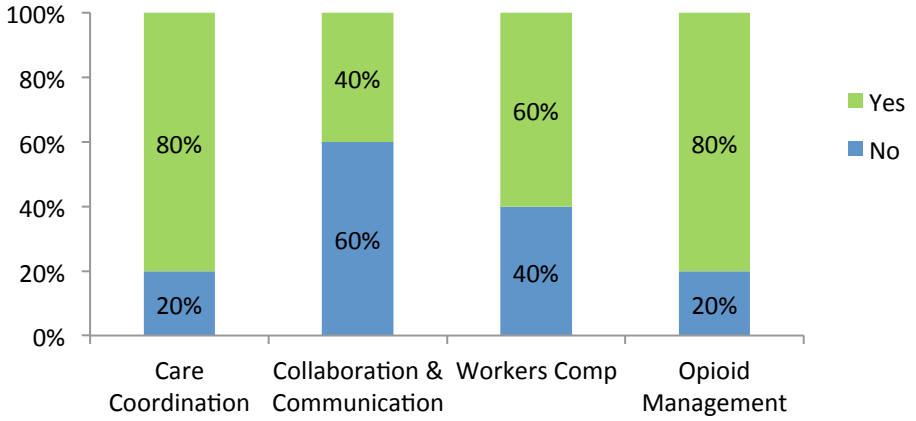


Reviewing claims

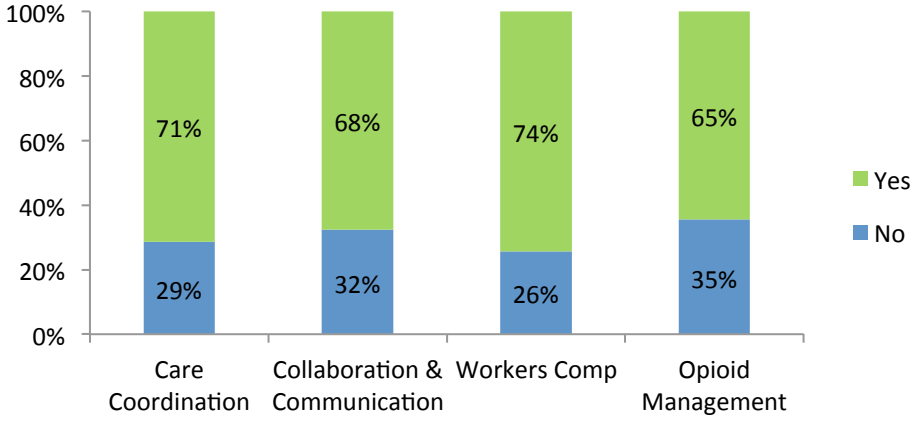
Reviewing claims, a reasonable measure?
All participants



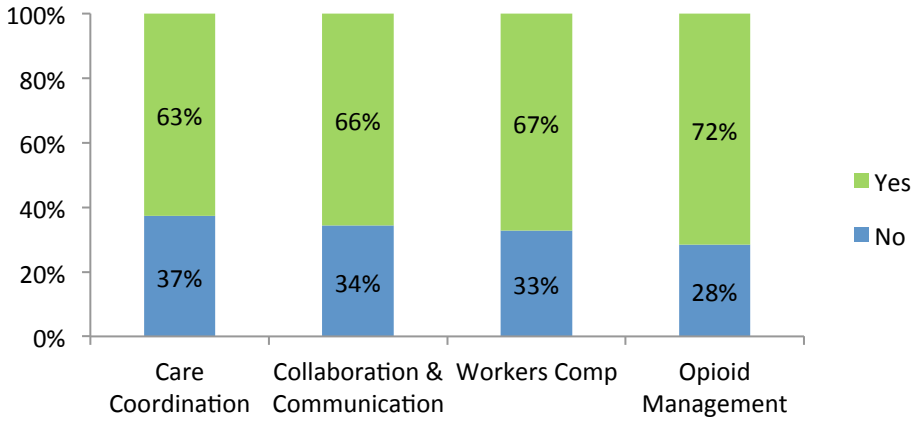
Reviewing claims, a reasonable measure?
ARNP



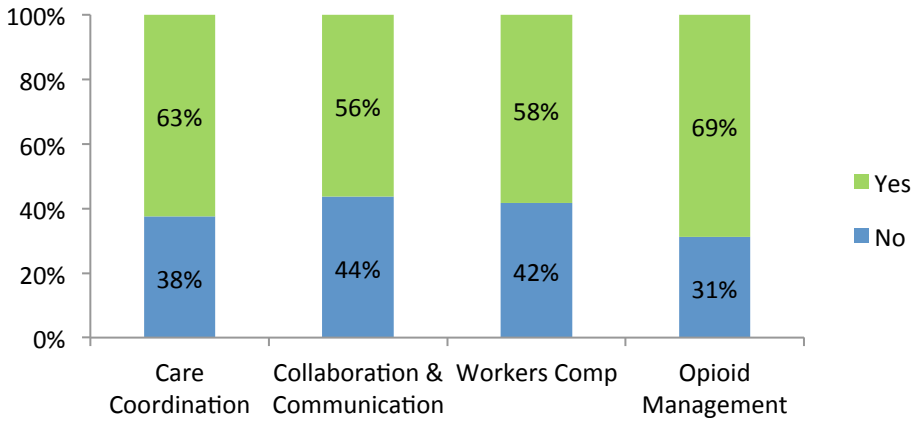
Reviewing claims, reasonable measure?
Chiropractors



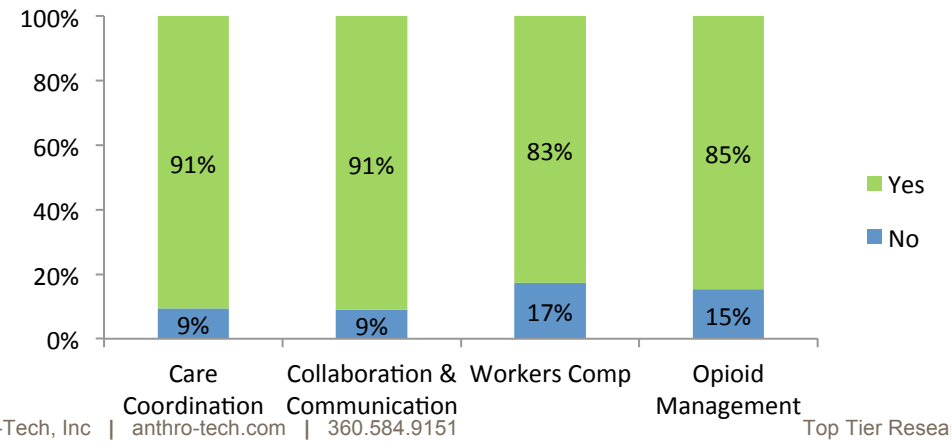
Reviewing claims, a reasonable measure? MD/DO



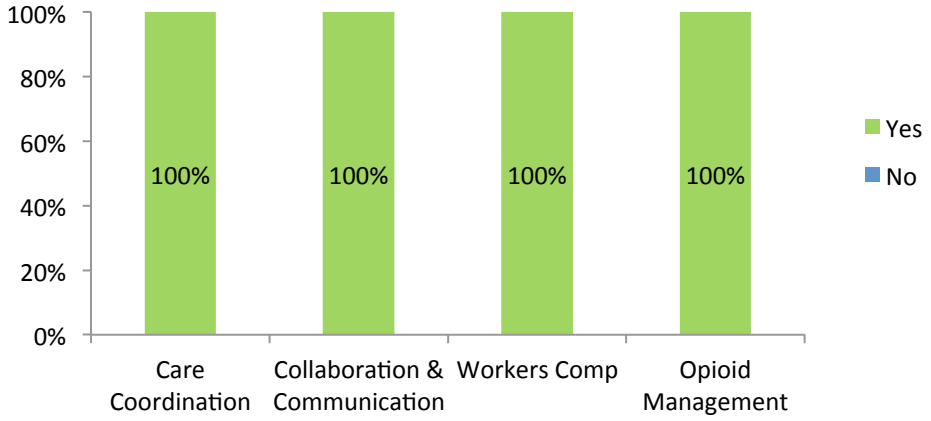
Reviewing claims, a reasonable measure? Podiatrists



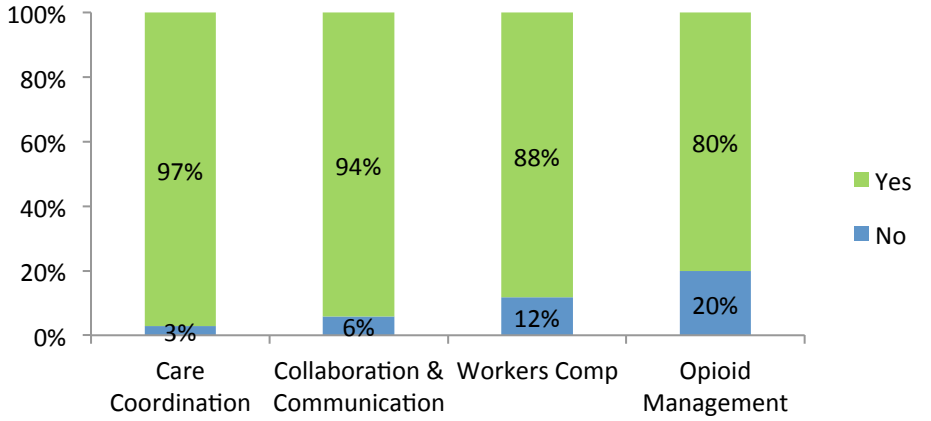
Better clinical or return to work outcomes? All participants



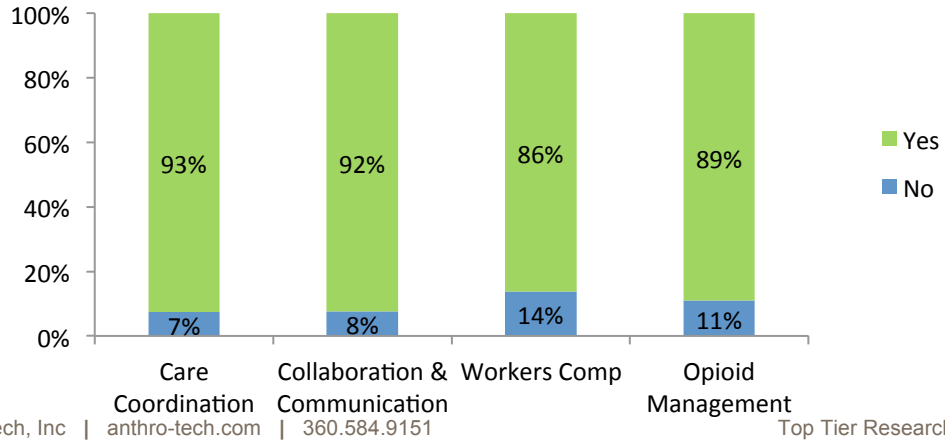
Better clinical or return to work outcomes? ARNP

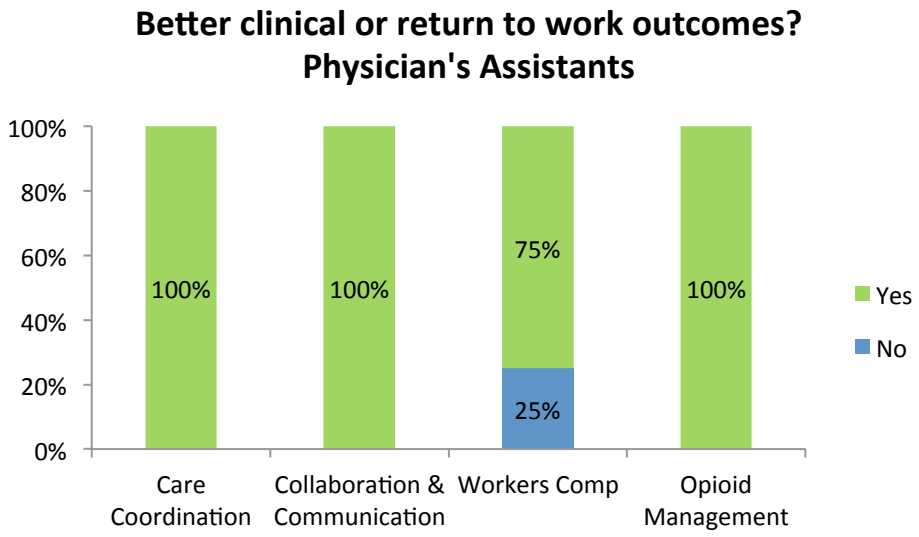


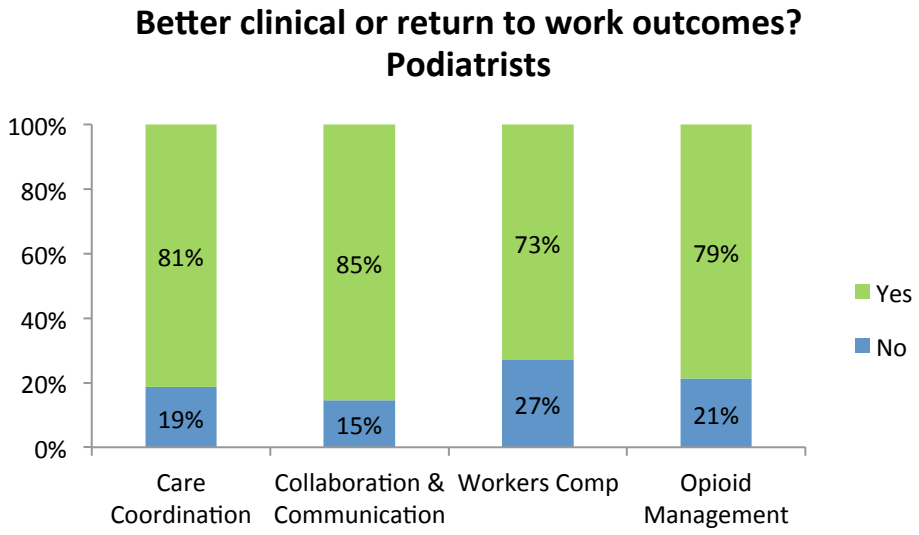
Better clinical or return to work outcomes? Chiropractors



Better clinical or return to work outcomes? MD/DO



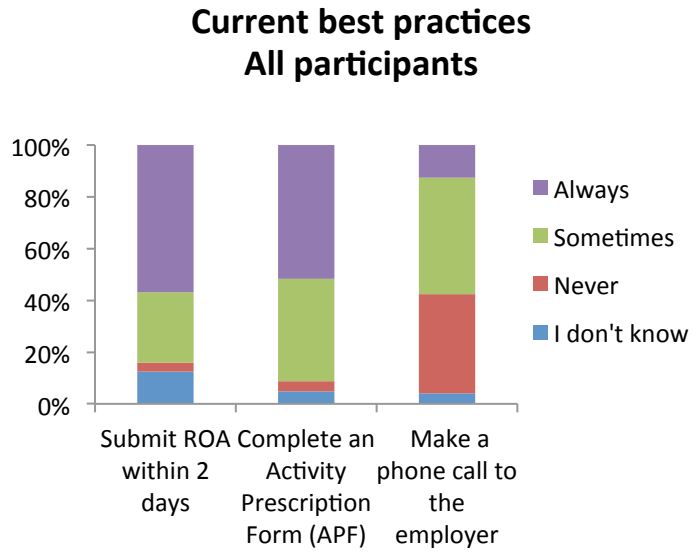

Better clinical or return to work outcomes?
Physician's Assistants
100%
80%
60%
40%
20%
0%
100%
100%
75%
25%
100%
Yes
No
Care Coordination
Collaboration & Communication
Workers Comp
Opioid Management

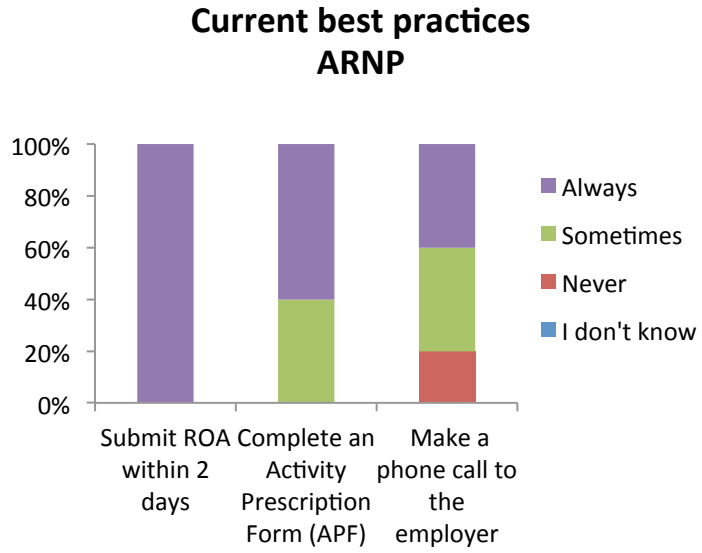

Better clinical or return to work outcomes?
Podiatrists
100%
80%
60%
40%
20%
0%
81%
19%
85%
15%
73%
27%
79%
21%
Yes
No
Care Coordination
Collaboration & Communication
Workers Comp
Opioid Management

Appendix E. Best practices by role

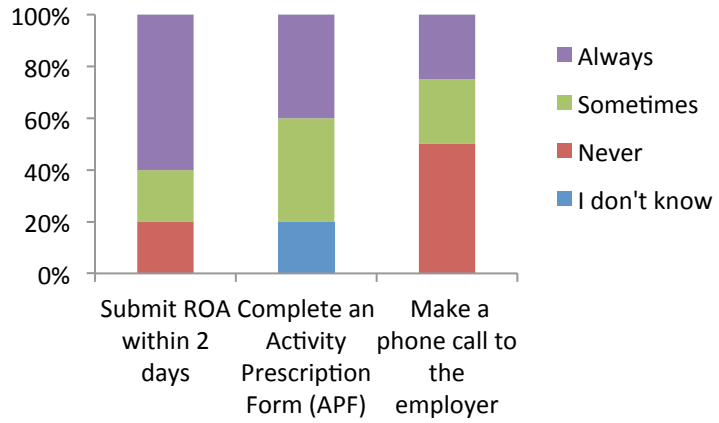
The following charts detail the responses of current adoption of best practices, overall and by role.

Currently implementing the best practices

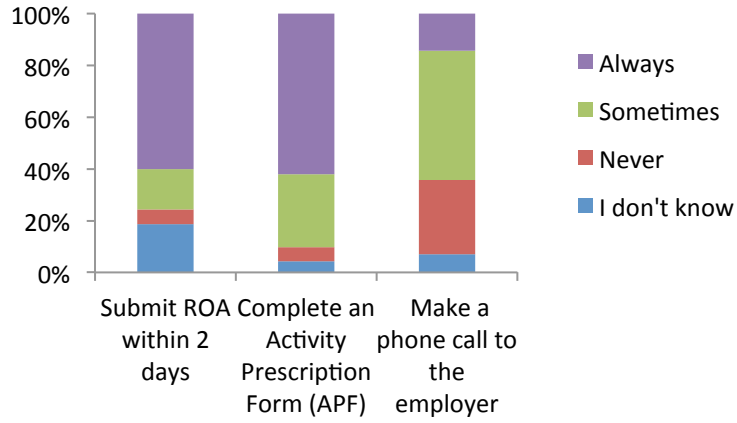




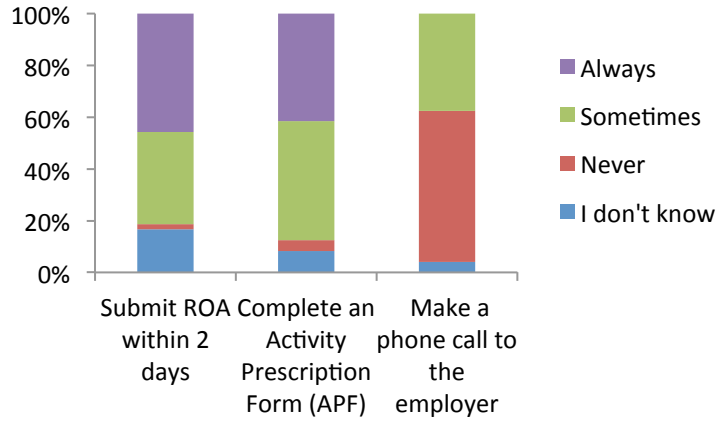
Current best practices
Physician's Assistants

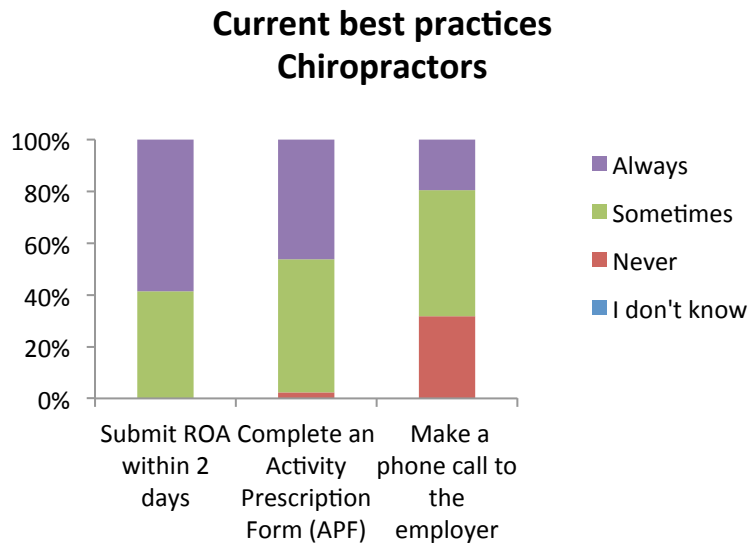


Current best practices
MD/DO

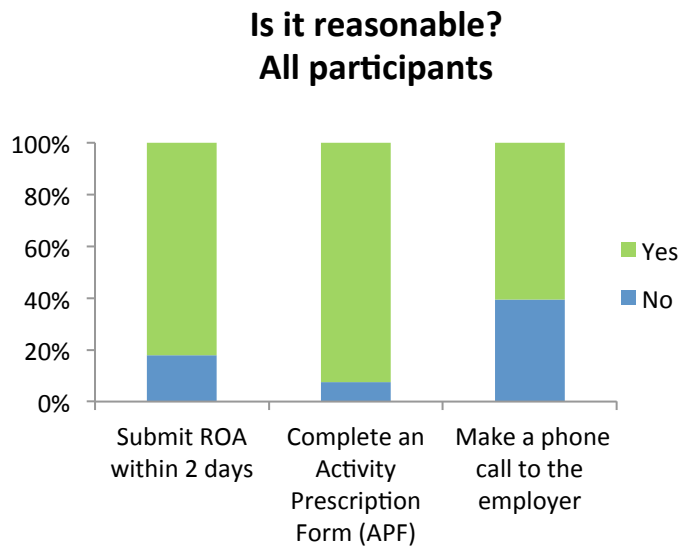


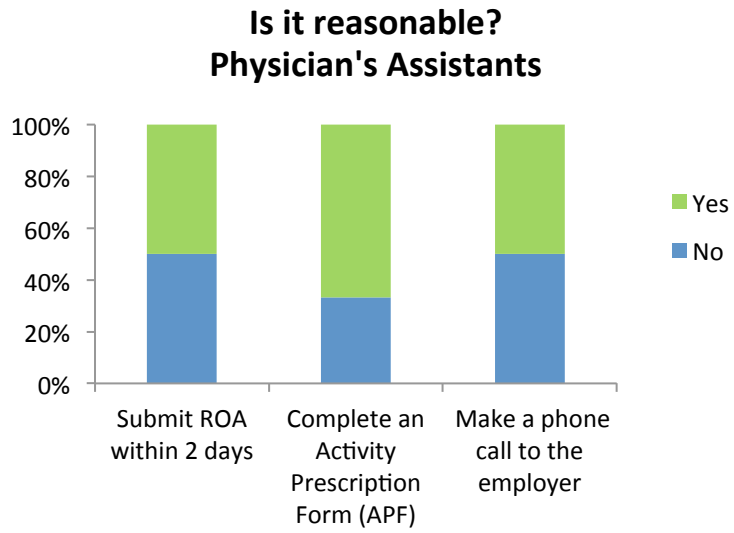
Current best practices
Podiatrists

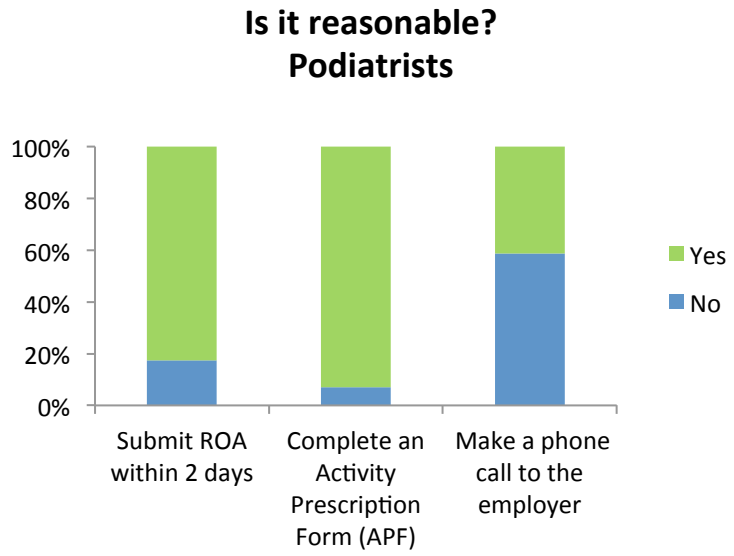


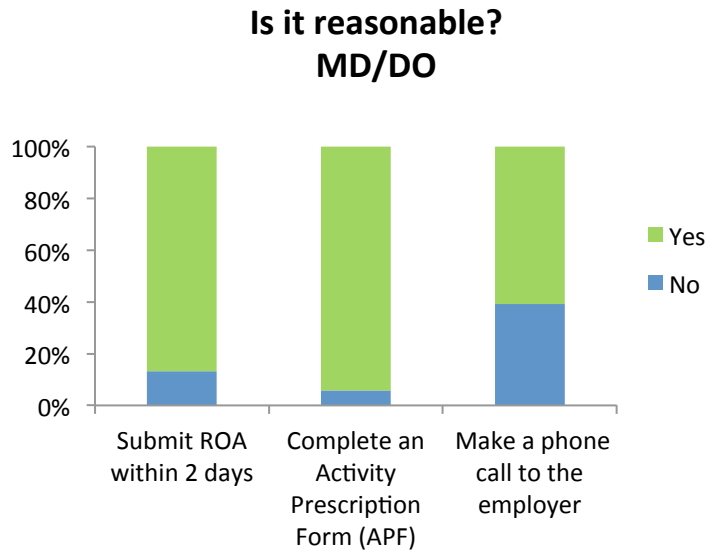


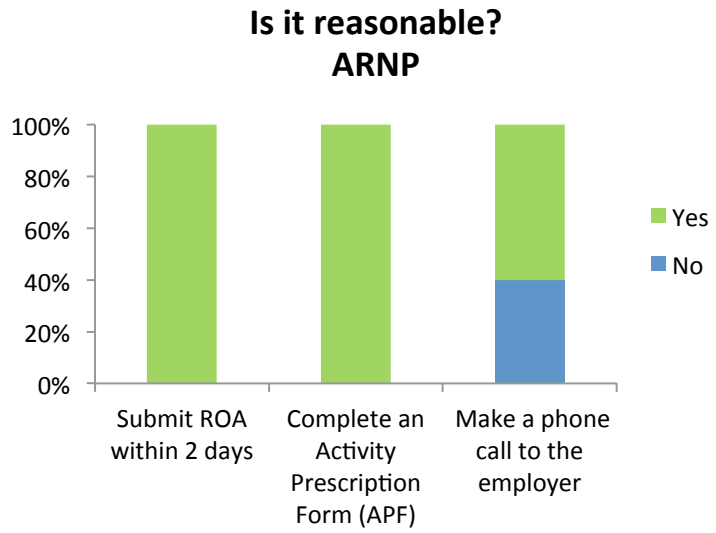
Are the best practices reasonable?

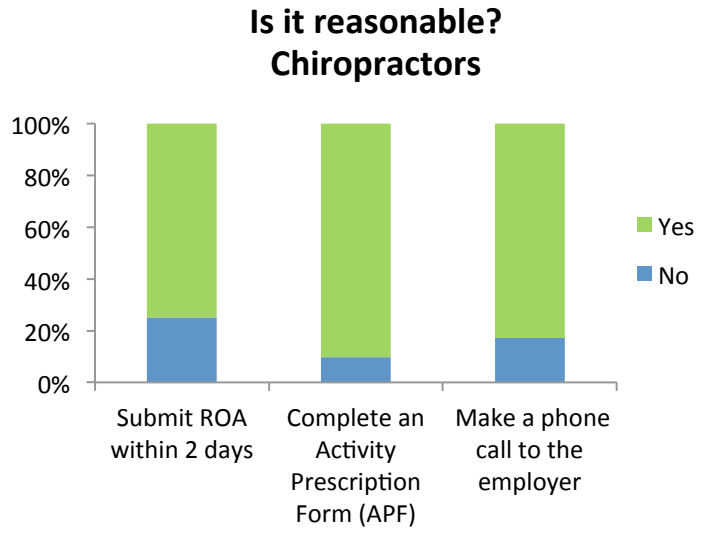



Is it reasonable?
Physician's Assistants
100%
80%
60%
40%
20%
0%
Submit ROA within 2 days
Complete an Activity Prescription Form (APF)
Make a phone call to the employer
Yes
No

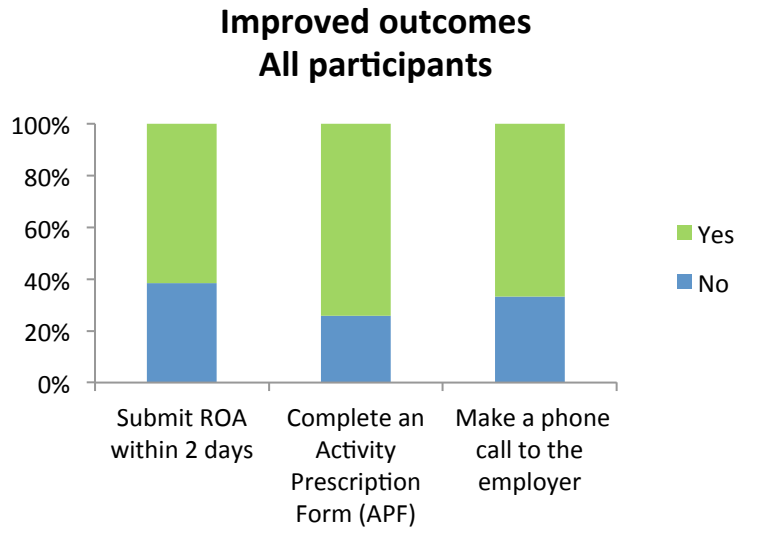

Is it reasonable?
Podiatrists
100%
80%
60%
40%
20%
0%
Submit ROA within 2 days
Complete an Activity Prescription Form (APF)
Make a phone call to the employer
Yes
No

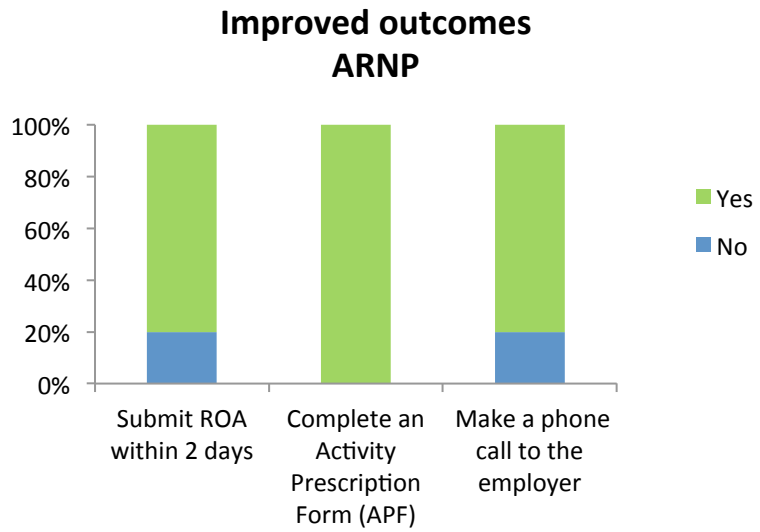

Is it reasonable?
MD/DO
100%
80%
60%
40%
20%
0%
Submit ROA within 2 days
Complete an Activity Prescription Form (APF)
Make a phone call to the employer
Yes
No


Is it reasonable?
ARNP
100%
80%
60%
40%
20%
0%
Submit ROA within 2 days
Complete an Activity Prescription Form (APF)
Make a phone call to the employer
Yes
No

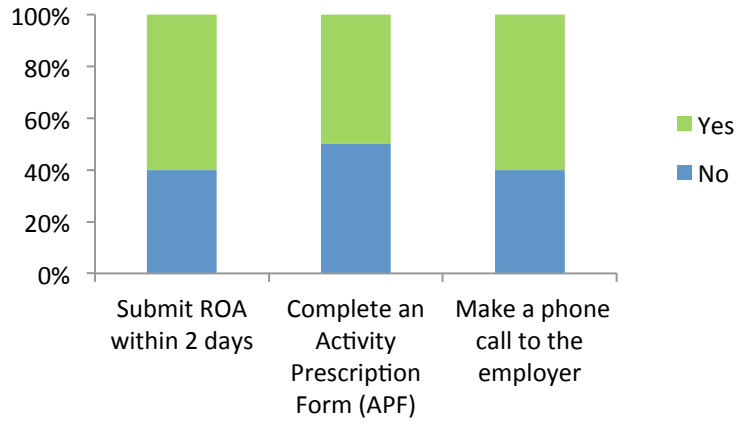

Is it reasonable?
Chiropractors
100%
80%
60%
40%
20%
0%
Submit ROA within 2 days
Complete an Activity Prescription Form (APF)
Make a phone call to the employer
Yes
No

Do the best practices lead to better outcomes?

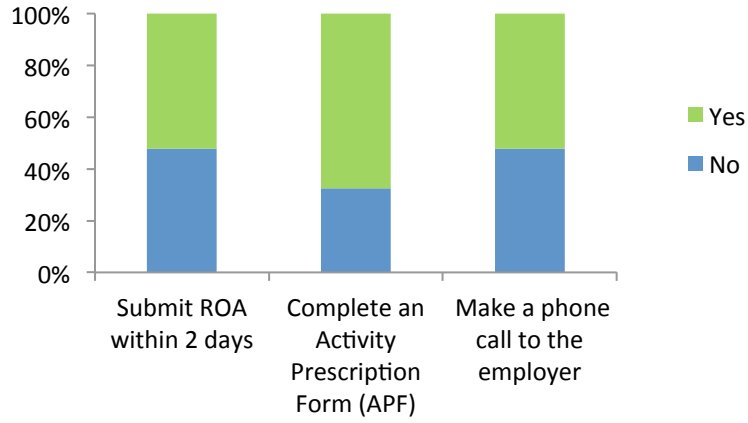




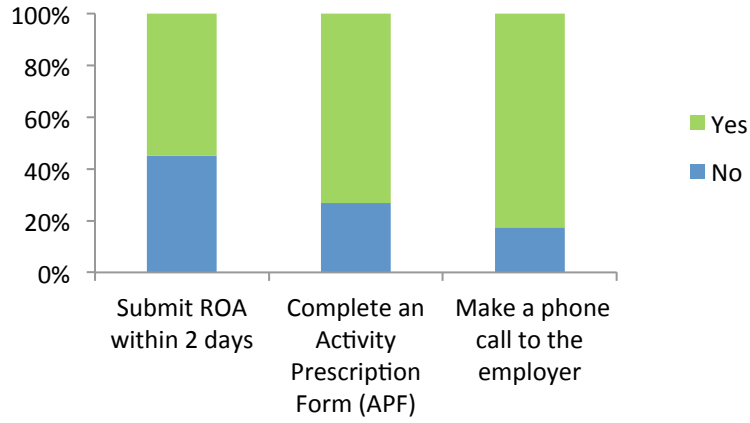
Improved outcomes Physician's Assistants

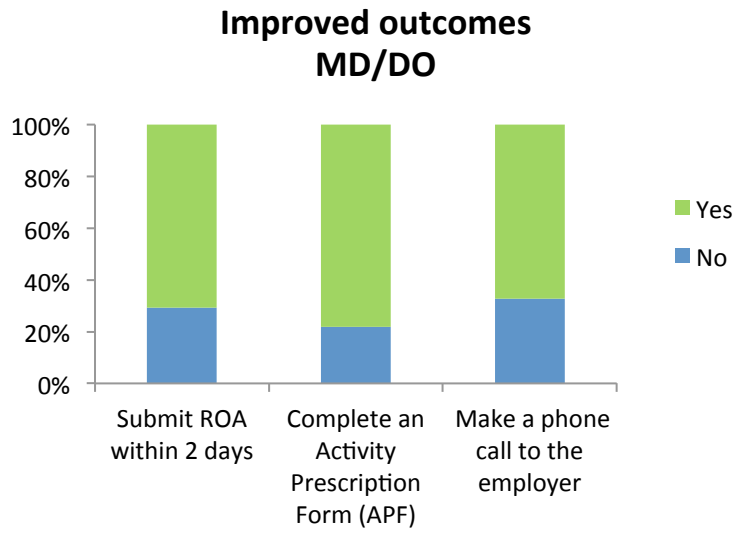


Improved outcomes Podiatrists

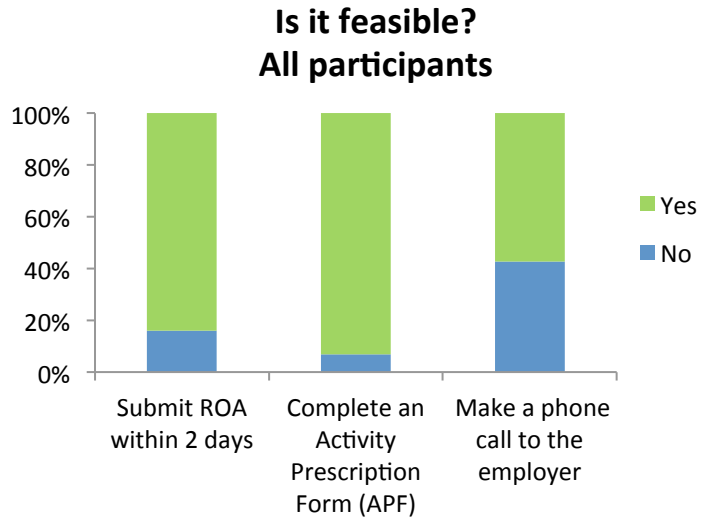


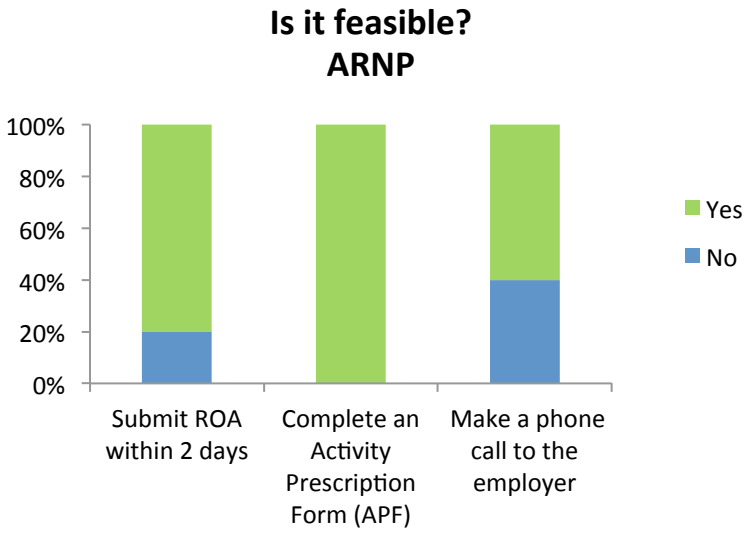
Improved outcomes Chiropractors

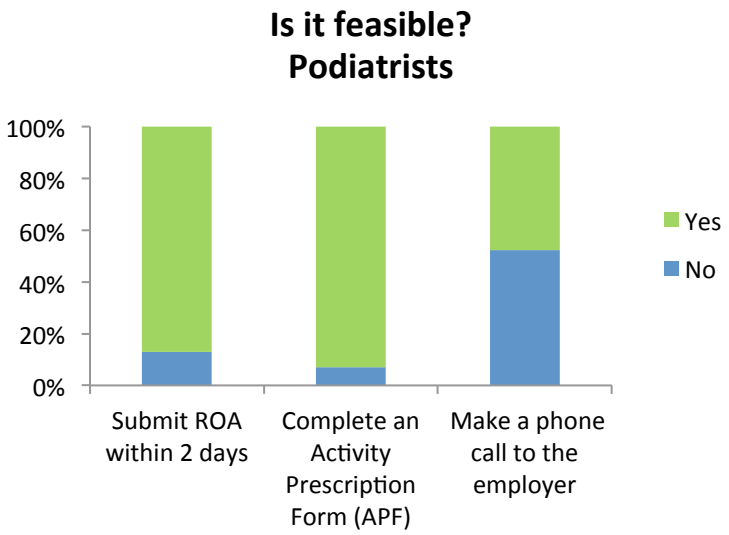


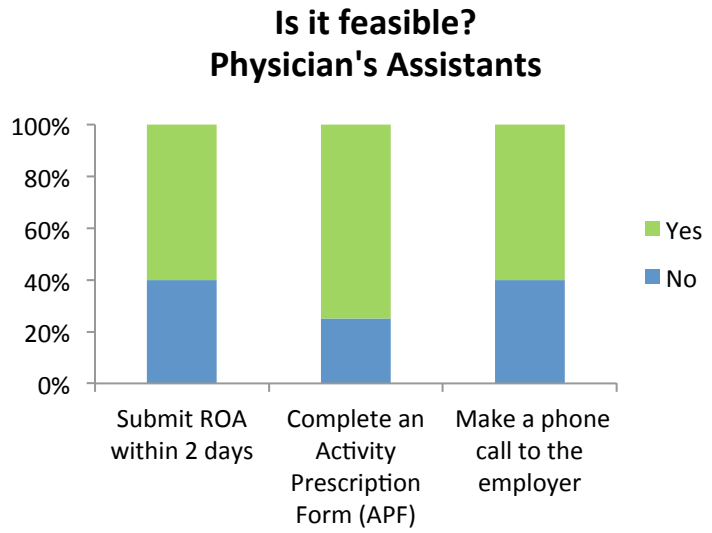


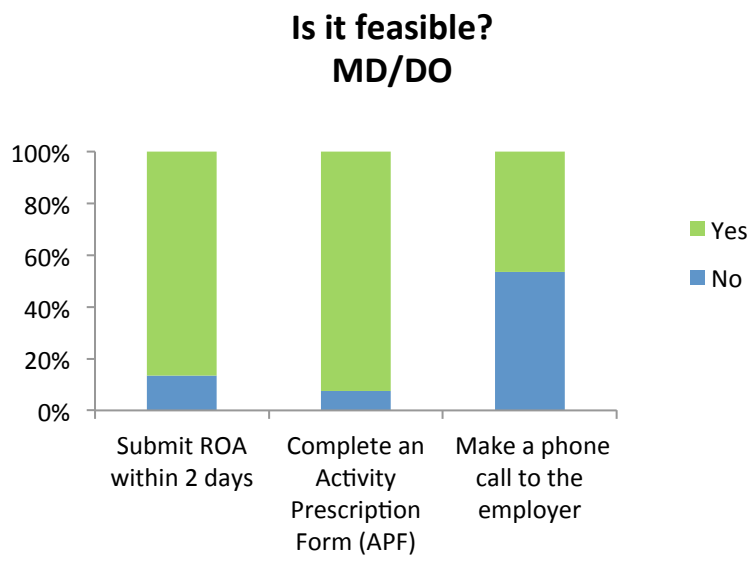
Is it feasible to implement the best practices in your clinic?

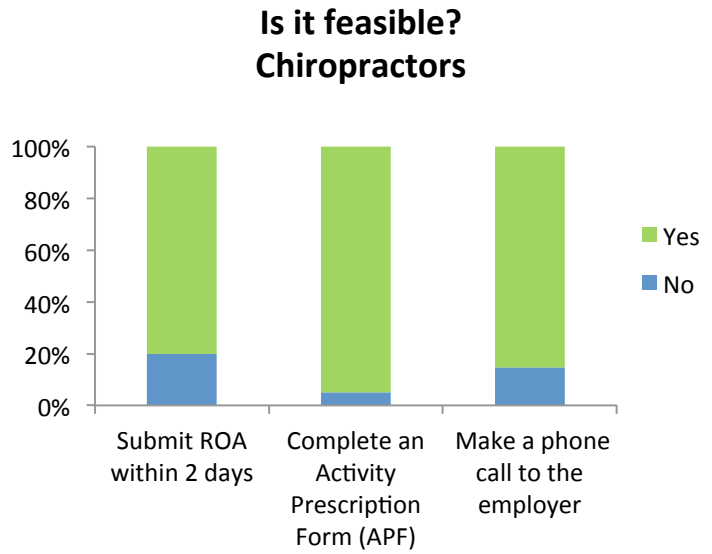



Is it feasible?
ARNP
100%
80%
60%
40%
20%
0%
Submit ROA within 2 days
Complete an Activity Prescription Form (APF)
Make a phone call to the employer
Yes
No

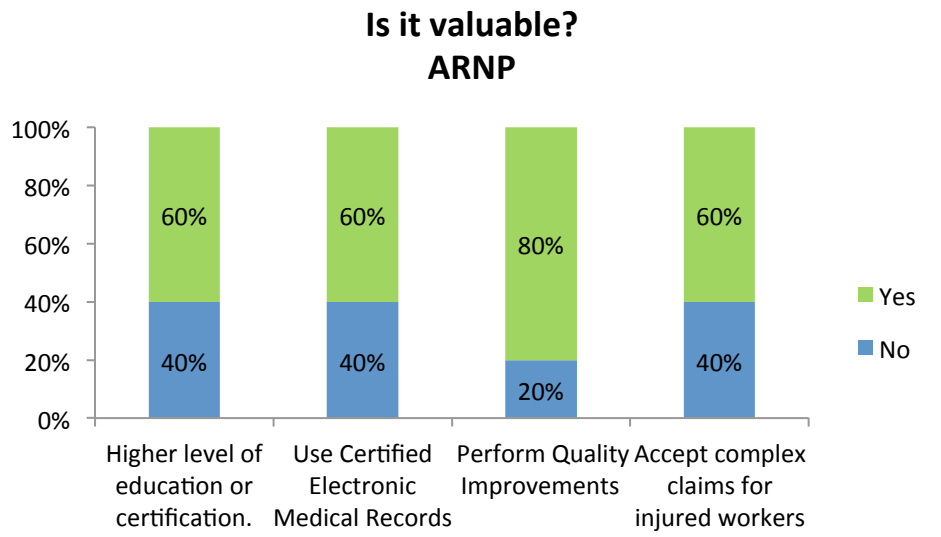

Is it feasible?
Podiatrists
100%
80%
60%
40%
20%
0%
Submit ROA within 2 days
Complete an Activity Prescription Form (APF)
Make a phone call to the employer
Yes
No

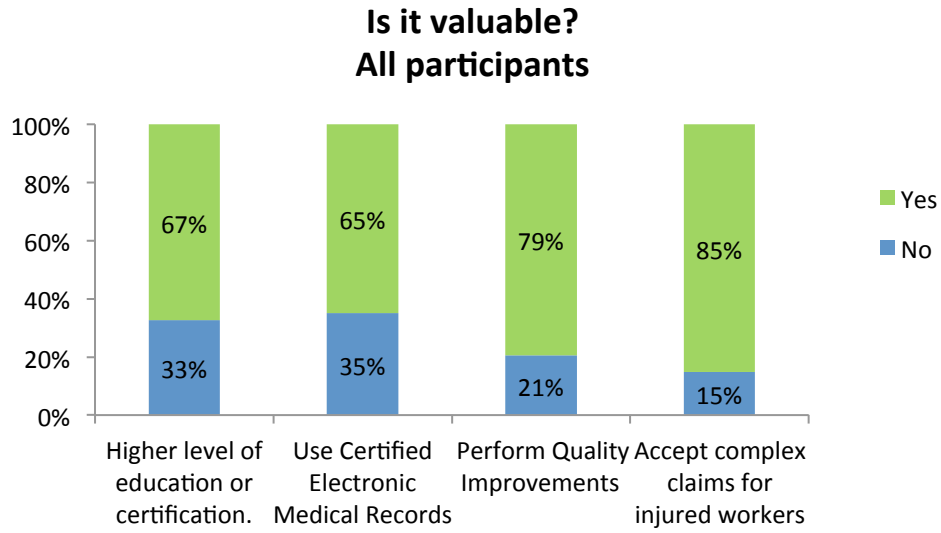

Is it feasible?
Physician's Assistants
100%
80%
60%
40%
20%
0%
Submit ROA within 2 days
Complete an Activity Prescription Form (APF)
Make a phone call to the employer
Yes
No

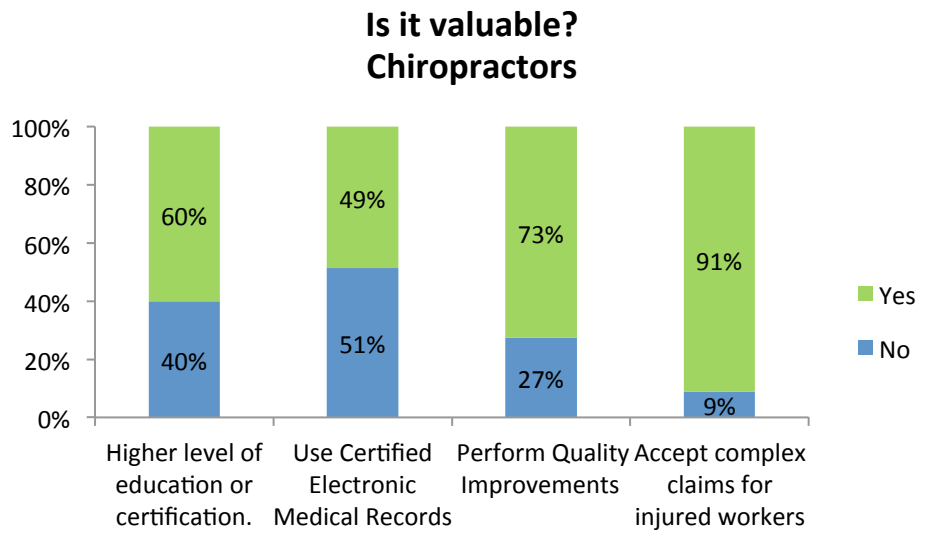

Is it feasible?
MD/DO
100%
80%
60%
40%
20%
0%
Submit ROA within 2 days
Complete an Activity Prescription Form (APF)
Make a phone call to the employer
Yes
No

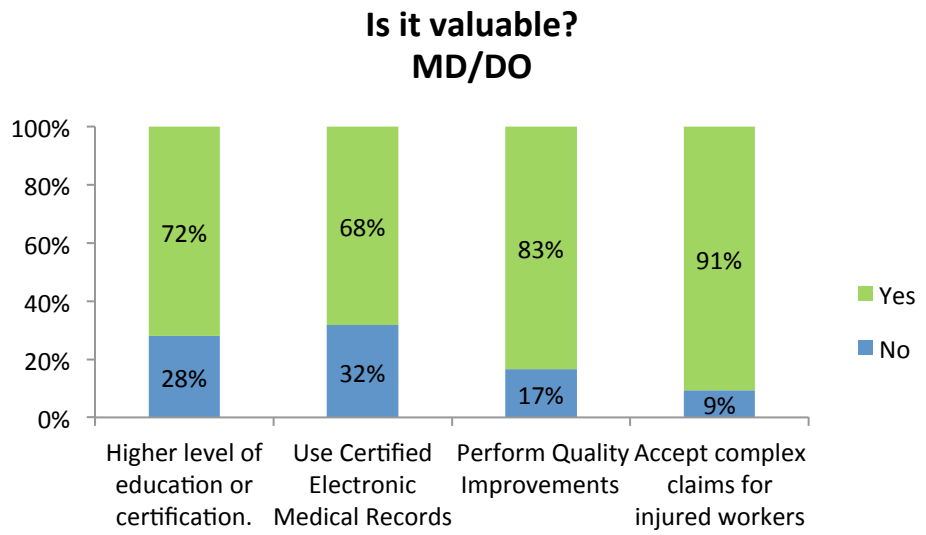

Is it feasible?
Chiropractors
100%
80%
60%
40%
20%
0%
Submit ROA within 2 days
Complete an Activity Prescription Form (APF)
Make a phone call to the employer
Yes
No

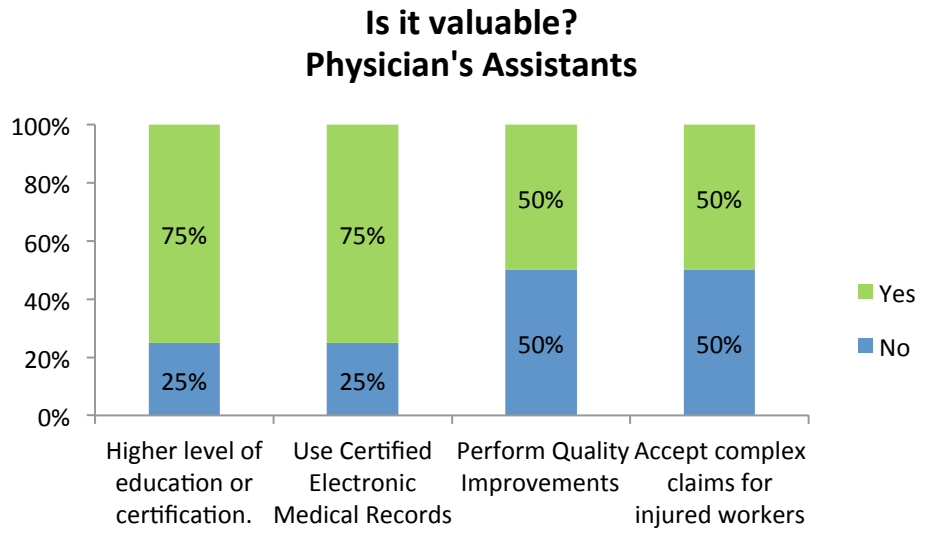
Appendix F. Additional qualifying criteria

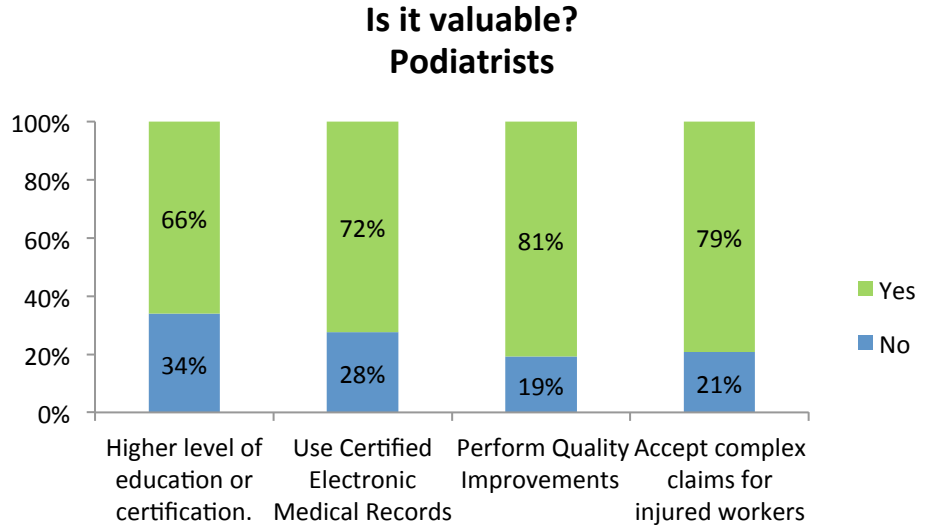




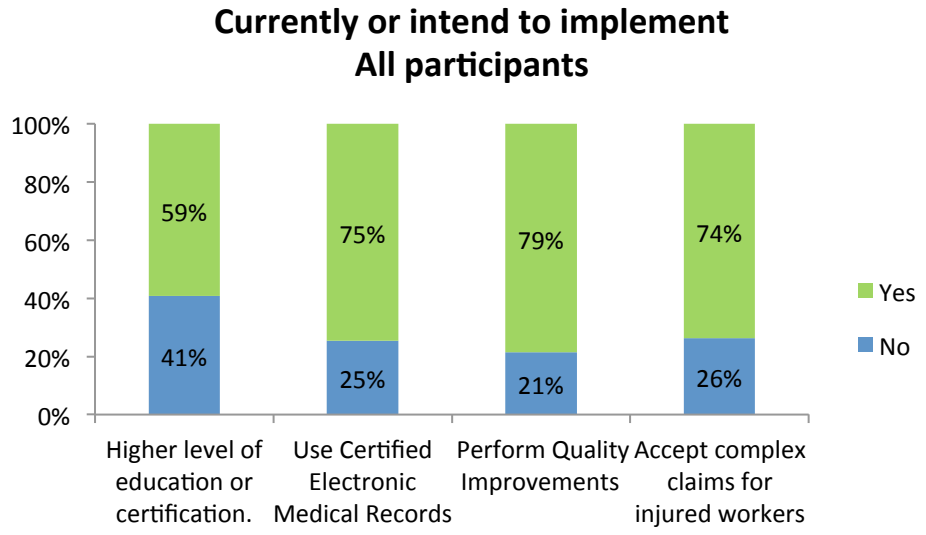

Is it valuable?
Chiropractors
100%
80%
60%
40%
20%
0%
60%
40%
49%
51%
73%
27%
91%
9%
Yes
No
Higher level of education or certification.
Use Certified Electronic Medical Records
Perform Quality Improvements
Accept complex claims for injured workers

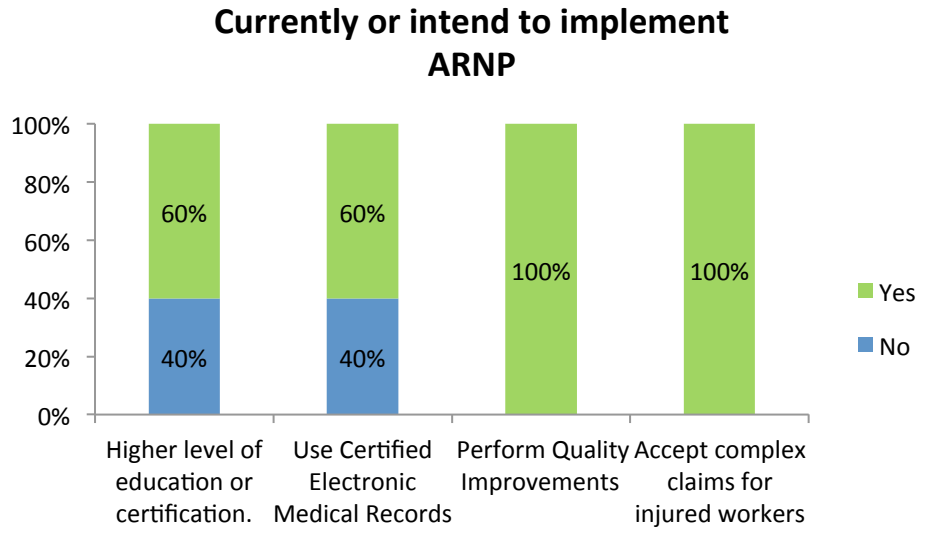

Is it valuable?
MD/DO
100%
80%
60%
40%
20%
0%
72%
28%
68%
32%
83%
17%
91%
9%
Yes
No
Higher level of education or certification.
Use Certified Electronic Medical Records
Perform Quality Improvements
Accept complex claims for injured workers

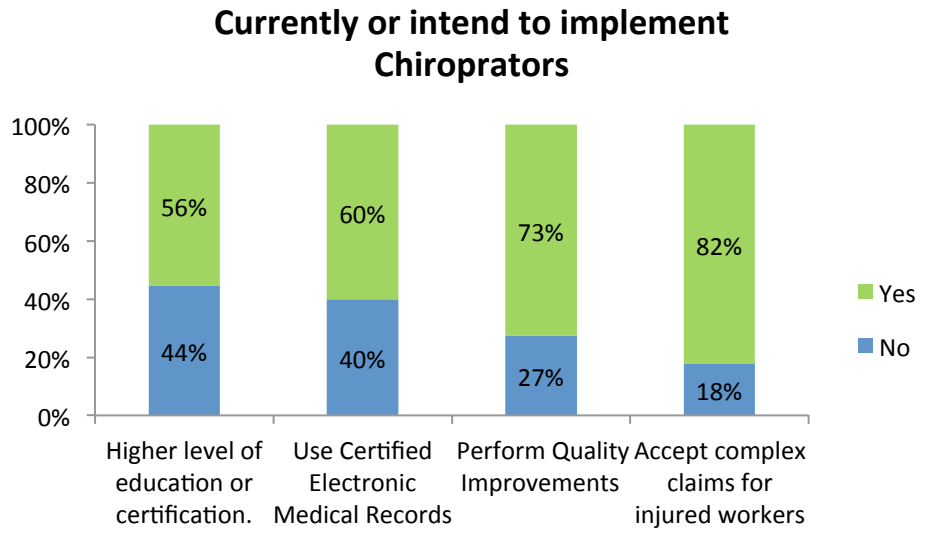

Is it valuable?
Physician's Assistants
100%
80%
60%
40%
20%
0%
75%
75%
50%
50%
25%
25%
50%
50%
Higher level of education or certification.
Use Certified Electronic Medical Records
Perform Quality Improvements
Accept complex claims for injured workers
Yes
No

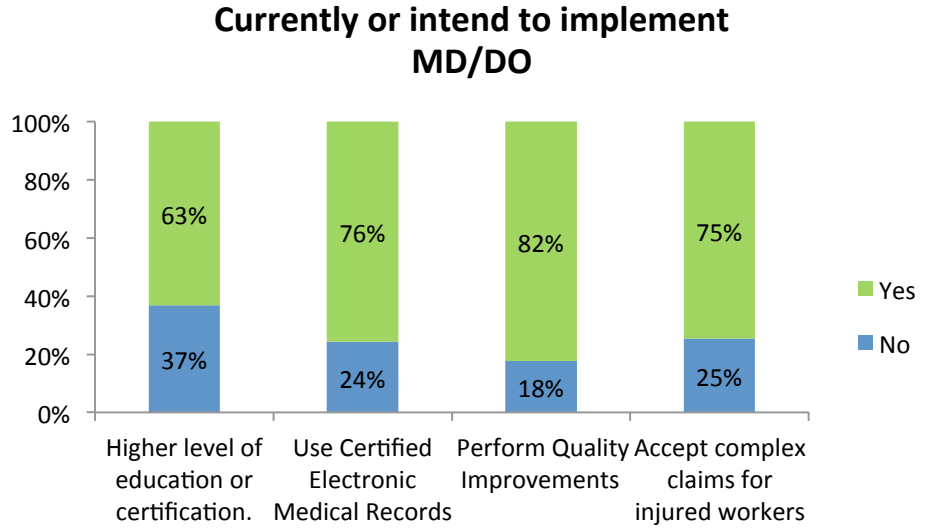

Is it valuable?
Podiatrists
100%
80%
60%
40%
20%
0%
66%
72%
81%
79%
34%
28%
19%
21%
Higher level of education or certification.
Use Certified Electronic Medical Records
Perform Quality Improvements
Accept complex claims for injured workers
Yes
No

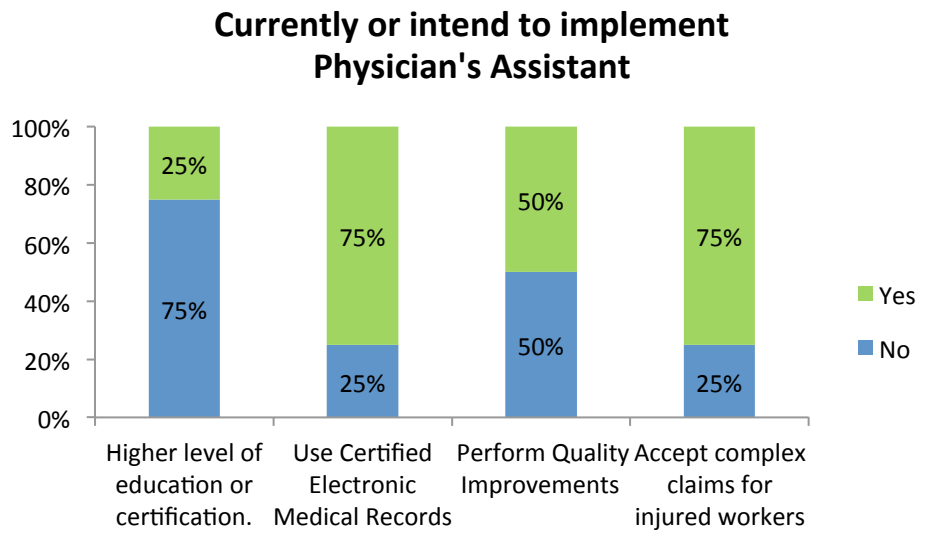
Currently have to intend to implement

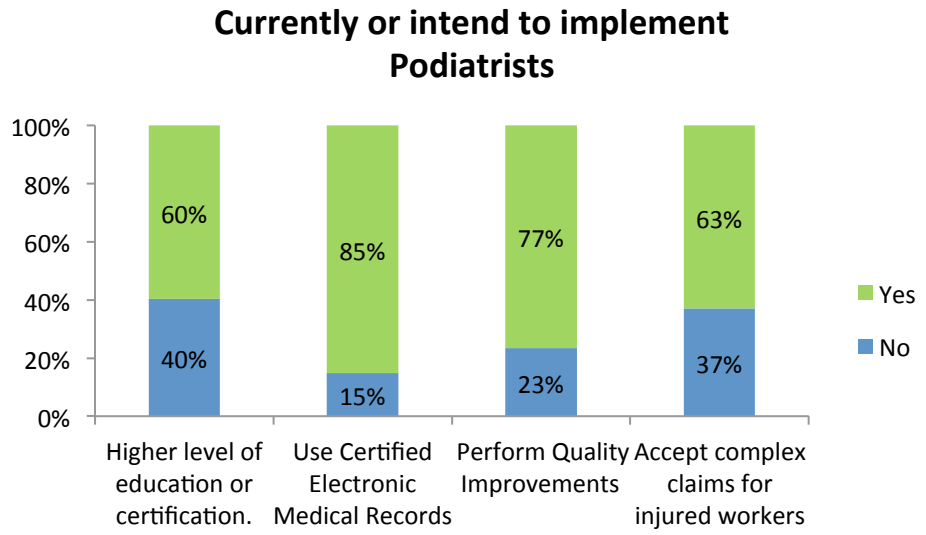




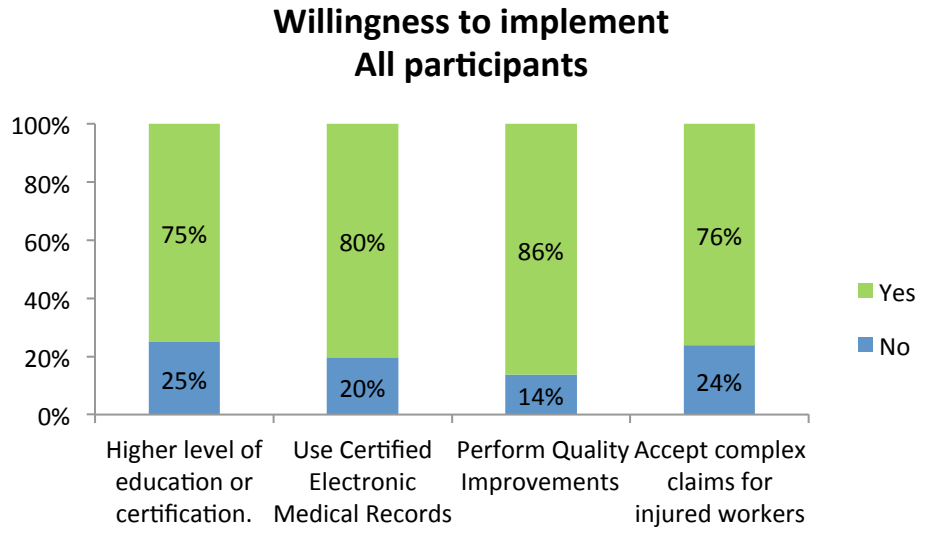

Currently or intend to implement Chiropractors
100%
80%
60%
40%
20%
0%
56%
44%
60%
40%
73%
27%
82%
18%
Yes
No
Higher level of education or certification.
Use Certified Electronic Medical Records
Perform Quality Improvements
Accept complex claims for injured workers

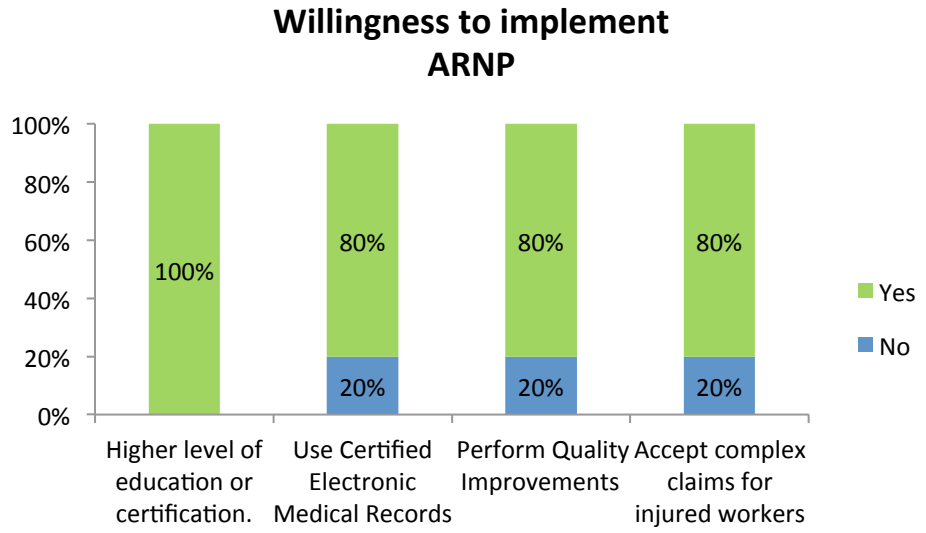

Currently or intend to implement MD/DO
100%
80%
60%
40%
20%
0%
63%
37%
76%
24%
82%
18%
75%
25%
Yes
No
Higher level of education or certification.
Use Certified Electronic Medical Records
Perform Quality Improvements
Accept complex claims for injured workers

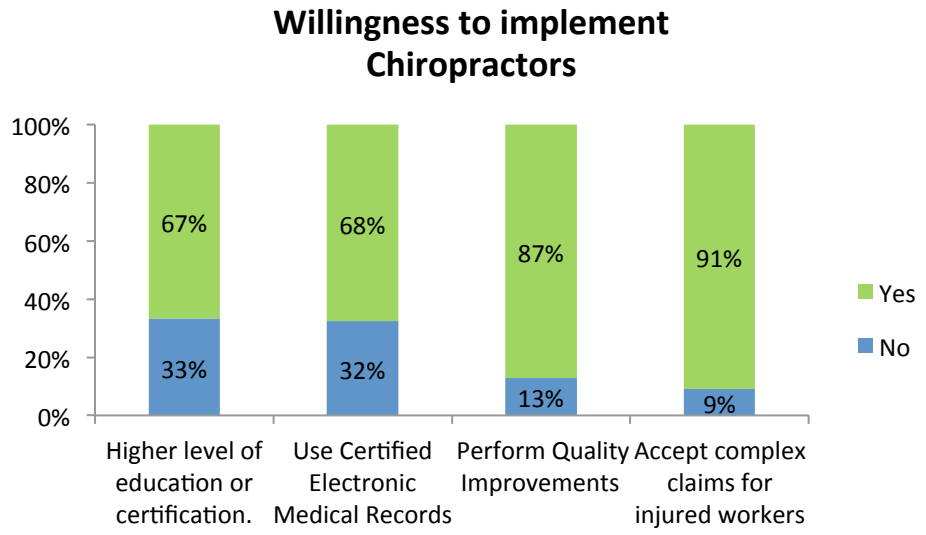

Currently or intend to implement Physician's Assistant
100%
80%
60%
40%
20%
0%
25%
75%
75%
25%
50%
50%
75%
25%
Yes
No
Higher level of education or certification.
Use Certified Electronic Medical Records
Perform Quality Improvements
Accept complex claims for injured workers

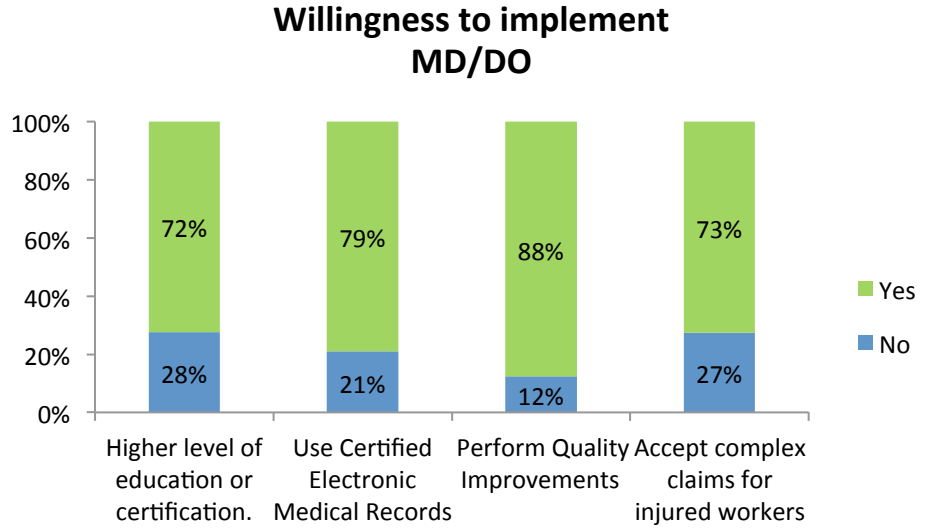

Currently or intend to implement Podiatrists
100%
80%
60%
40%
20%
0%
60%
40%
85%
15%
77%
23%
63%
37%
Yes
No
Higher level of education or certification.
Use Certified Electronic Medical Records
Perform Quality Improvements
Accept complex claims for injured workers

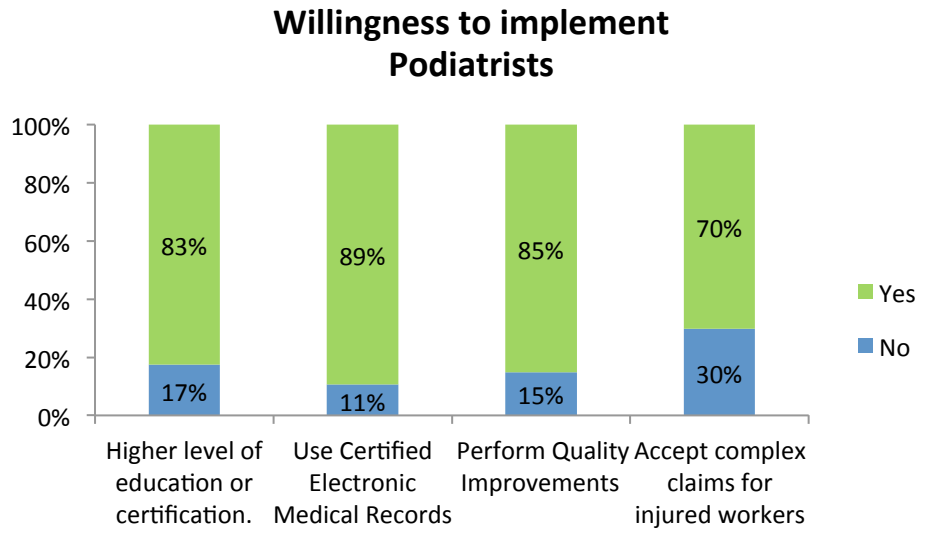
Willing to implement

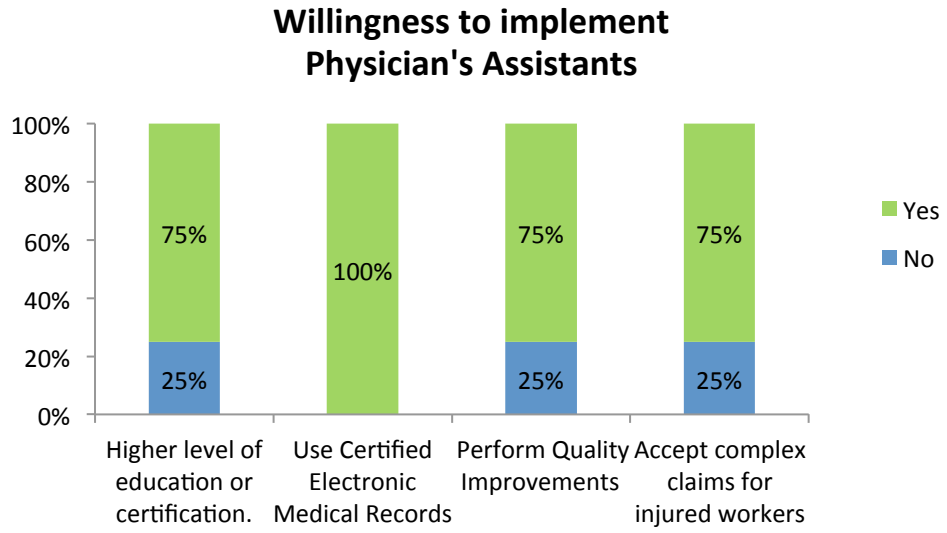





Willingness to implement Chiropractors
100%
80%
60%
40%
20%
0%
67%
68%
87%
91%
33%
32%
13%
9%
Higher level of education or certification.
Use Certified Electronic Medical Records
Perform Quality Improvements
Accept complex claims for injured workers
Yes
No


Willingness to implement MD/DO
100%
80%
60%
40%
20%
0%
72%
79%
88%
73%
28%
21%
12%
27%
Higher level of education or certification.
Use Certified Electronic Medical Records
Perform Quality Improvements
Accept complex claims for injured workers
Yes
No


Willingness to implement Podiatrists
100%
80%
60%
40%
20%
0%
83%
89%
85%
70%
17%
11%
15%
30%
Yes
No
Higher level of education or certification.
Use Certified Electronic Medical Records
Perform Quality Improvements
Accept complex claims for injured workers


Willingness to implement Physician's Assistants
100%
80%
60%
40%
20%
0%
75%
100%
75%
75%
25%
25%
25%
Yes
No
Higher level of education or certification.
Use Certified Electronic Medical Records
Perform Quality Improvements
Accept complex claims for injured workers